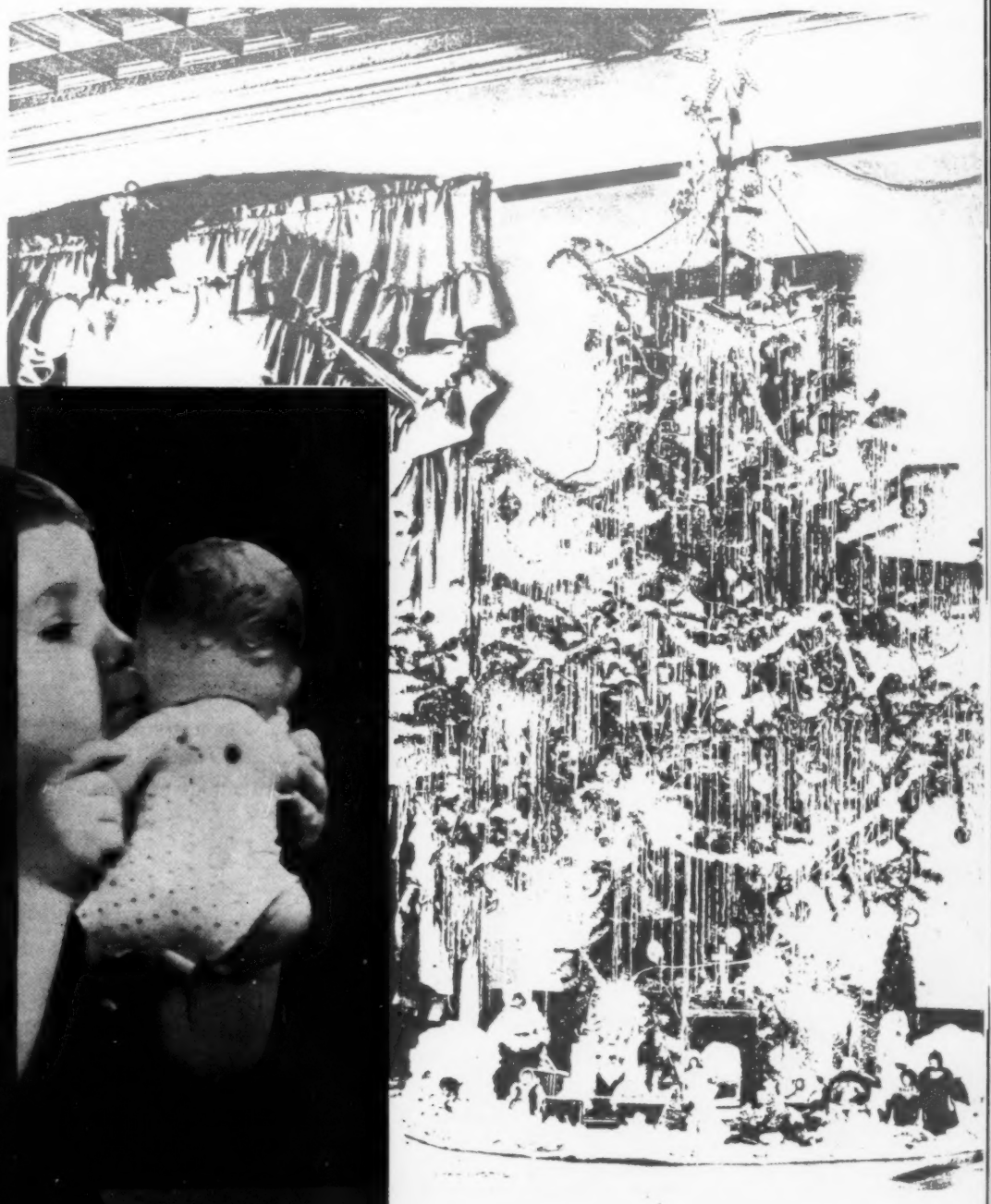
December 1961

Mental Hospitals

Hospital Journal
of the American Psychiatric Association



Three Christmas Stories

. . . *see Page 26*

Volume 12 Number 12

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Mental Hospitals

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AMERICAN PSYCHIATRIC ASSOCIATION

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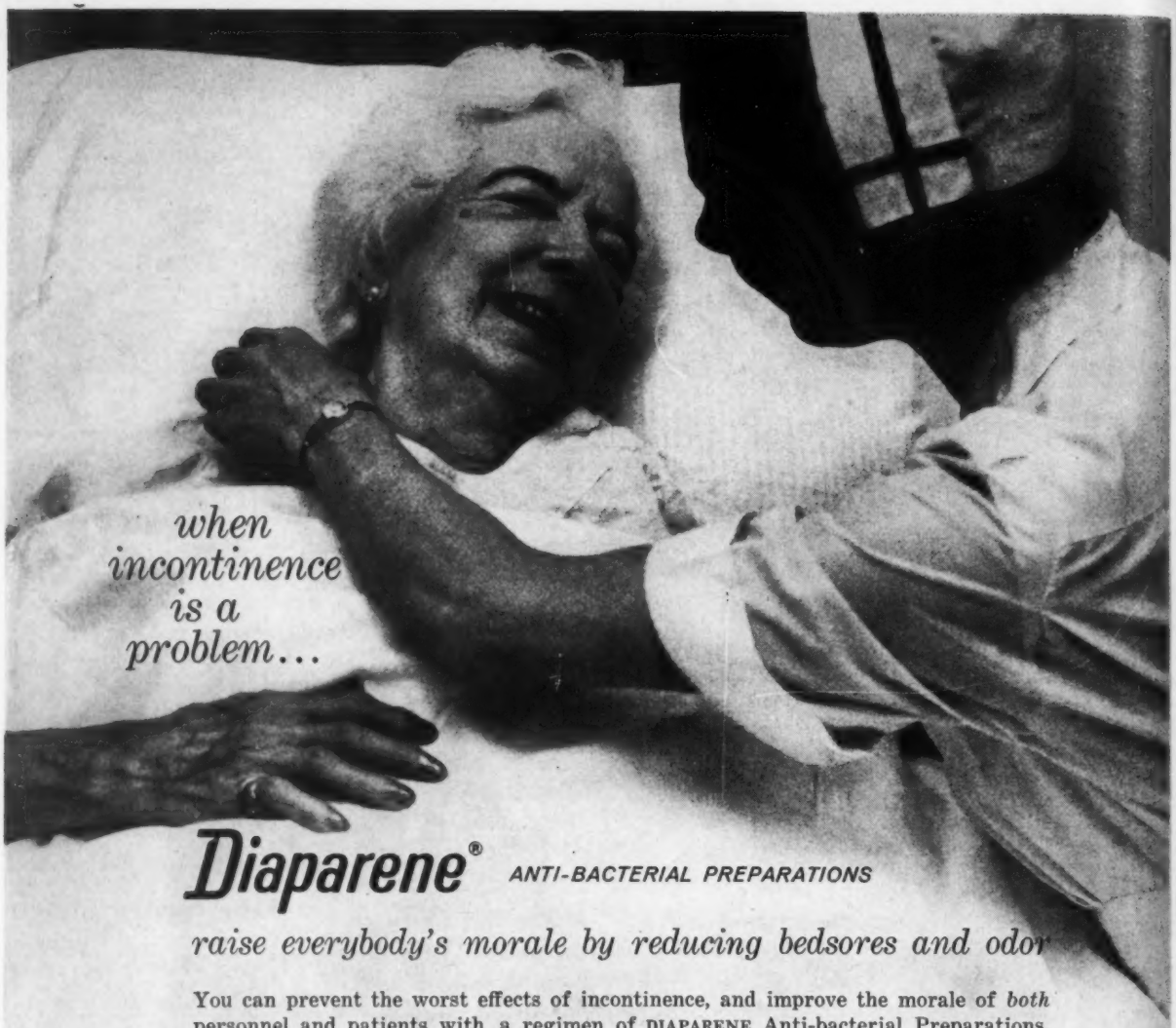
MENTAL HOSPITALS offers a forum for free discussion about matters of interest to persons involved in the care and treatment of psychiatric patients. Opinions expressed by the authors are theirs and do not necessarily represent the official policy of the American Psychiatric Association.



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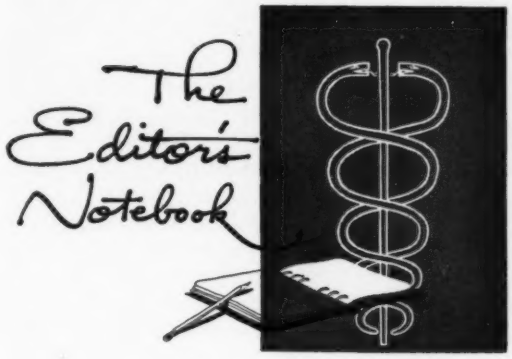
*Shovlain, F. E.; Brown, R. W.; Delaney, G. A.; and Lelli, F. P.: Hospitals *33*:61 (June 1) 1959.



One of the most controversial recommendations of the final report of the Joint Commission on Mental Illness and Health is that concerning the care of the chronically ill, including the aged.

"Special techniques are available for the care of the chronically ill," reads this recommendation, "and these techniques of socialization, relearning, group living, and gradual rehabilitation or social improvement should be expanded and extended to many people, including the aged who are sick and in need of care, through conversion of State mental hospitals into combined chronic disease centers."

Had the last phrase of the sentence been omitted, however, there would be no room for controversy. There is little question but that the proportion of elderly people in our mental hospitals is increasing very rapidly. In addition to their psychiatric symptoms, these patients present a number of physical disabilities which constitute a severe burden on the professional staff of the hospital. How to deal with these problems provides psychiatrists and other psychiatric staff with many opportunities for service, education, and research.

In Amsterdam, reactivation centers have been established. These are essentially hospitals with extended rehabilitation facilities, separated geographically from general hospitals, but functioning in cooperation with them. Within these centers, about 50 beds are set aside for the elderly and confused. Psychiatrists and internists supervise these patients and have confirmed what has long been known: many of these old people, when properly hydrated and adequately nurtured, lose much of their confusion. Such centers, when related properly to patients in their own homes, can provide a continuum of services, leading to decreased morbidity and increased continuity of service and social restoration.

In Sweden, where medical schools teach social medicine courses in the care of the aged and of those with long term illnesses, it is believed that the internist should care for the elderly. Although the shortage of physicians is a complicating factor, such a plan could do away with the need for geriatric clinics. But emphasis is needed on both social and medical aspects of the problem if we are to prevent, retard, and eliminate the problems of mental and physical deterioration.

At the recent White House Conference on Aging, it was stated that several universities have established divisions or institutes of gerontology which offer opportunities for training and research in the basic sciences and clinical fields for undergraduates and graduates, as well as for allied medical personnel. One third of the formal course-content in public health medicine concerns the treatment of the chronically ill and the aging, and considerable attention is devoted to community action in these fields. There is also evidence that social work courses are preparing students to render services to these groups. Nor are recreation and adult education for the senior citizen neglected in the curricula of some 80 colleges and universities. A number of religious groups are offering special training in handling the social and spiritual problems of older people. A rather notable exception occurs in the field of nursing, which, at the moment, includes little, if any, education in geriatrics.

There are even indications that architects are beginning to interest themselves in designing suitable buildings for older people, and much remains to be done in this key area. Late this summer, I noted with interest that the AHA and the USPHS announced the creation of a jointly sponsored committee to develop recommendations on planning facilities for long-term patient-care.

Today's physician is confronted by patients who present a number of chronic, disabling, and debilitating disorders with which he has been poorly equipped to deal. These disorders most often occur in those persons whose life has been prolonged by the advances of medical science. One thing is certain—the problems of the aging citizen won't go away. The responsibility of the individual physician and of the health professions as a whole is to meet the needs of the persons whom these professions were developed to serve. The needs of the people must dictate all our activities. It behooves the psychiatrist and his colleagues to devote their skills in treatment, training, and research to the growing legions of aging citizens.

Matthew Ross, M.D.

National Action Against Mental

AT HIS OCTOBER 10 PRESS CONFERENCE, President Kennedy made an announcement—not about how to prevent or survive the possible ravages of nuclear war, but how to defeat a condition that "strikes those least able to protect themselves from it." It was his intention, he said, "to appoint a panel of outstanding scientists, doctors and others, to prescribe a program of action in the field of mental retardation."

The President's full and definitive statement is one that will encourage—and affect—everyone engaged in helping the mentally retarded. His press conference statement follows:

". . . I have announced my intention to appoint a panel of outstanding scientists, doctors, and others, to prescribe a program of action in the field of mental retardation. This condition strikes those least able to protect themselves from it. It affects not only the people involved, but also the members of their families. It is a serious personal matter to at least one out of every 12 persons. It disables 10 times as many as diabetes, 20 times as many as tuberculosis, 25 times as many as muscular dystrophy and 600 times as many as infantile paralysis.

"At one time there was practically no effective program in the field of mental retardation. Wherever possible the children were committed to institutions. They were segregated from normal society and forgotten except by the members. Only in isolated cases was an effort made to bring them back into useful lives in the community. They suffered from lack of public understanding and they suffered from lack of funds.

"The situation today is better. Most attempts still take the form of therapeutic research and treatment. The central problems of causes and prevention remain unsolved. And I believe that we as a country, in association with scientists all over the world, should make a comprehensive attack. It is a matter of the greatest possible interest to me, and I am going to meet with the panel next week."

Actually, the President met with the 24-member panel less than a week after declaring his intention to spur action in behalf of the nation's mentally retarded. As chairman of the panel, he named Leonard Mayo, M.D., executive director of the Association for the Aid of Crippled Children, New York City. George Tarjan, M.D., superintendent of Pacific State Hospital (for the retarded), Pomona, Cal., as vice chairman. Other members of the panel are: Elizabeth Boggs, M.D., research chairman, National Association for Retarded Children, New York; William Hurder, M.D., associate director for mental health, Southern Regional Education Board, Atlanta; Seymour S. Kety, M.D., psychiatrist-in-chief, Henry Phipps Psychiatric Clinic, Johns Hopkins Hospital; Reginald Spencer Lourie, M.D., director of the Department of Psychiatry, Children's Hospital, Washington.

Following is a statement by the President regarding the need for a national program:

"The manner in which our Nation cares for its citizens and conserves its manpower resources is more than an index to its concern for the less fortunate. It is a key to its future. Both wisdom and humanity dictate a deep interest in the physically handicapped, the mentally ill, and the mentally retarded. Yet, although we have made considerable progress in the treatment of physical handicaps, although we have attacked on a broad front the problems of mental illness, although we have made great strides in the battle against disease, we as a nation have for too long postponed an intensive search for solutions to the problems of the mentally retarded. That failure should be corrected.

What is Mental Retardation?

"The term mental retardation itself is often misunderstood. It is confused with mental illness. Simply stated, mental retardation is a condition resulting from a basic abnormality of the human mind. It refers to the lack of intellectual ability resulting from arrested mental development. It interferes with the ability to adjust to the demands of environment. It manifests itself in poor learning, inadequate social adjustment, and delayed achievement. Usually this condition is either present at birth or begins during childhood. The causes are many and obscure. Some have already been determined and are easy to highlight; others are beyond our present knowledge and would yield only to research.

"Mental retardation is not a disease. Rather, it is a symptom of a disease, of an injury, of some obscure failure of development, even of inadequate opportunity to learn. Just as a fever is a symptom of an infection, mental retardation is a symptom of mongolism, birth injury, or infection, or even inadequate stimulation in early childhood. It can be so severe that the afflicted person never leaves protective care, or so mild that it is detected only under stress or through special tests.

"In most instances, it can be clearly distinguished from mental illness, for mental illness strikes and incapacitates after there has been normal development up to the time of the affliction. The younger the child the more difficult it is to distinguish between the two. However, accurate diagnosis is an essential prelude to treatment. Unfortunately, the present limitations of our knowledge in this field make this

Retardation

diagnosis extremely difficult when the very young are involved.

I. The Scope of the Problem

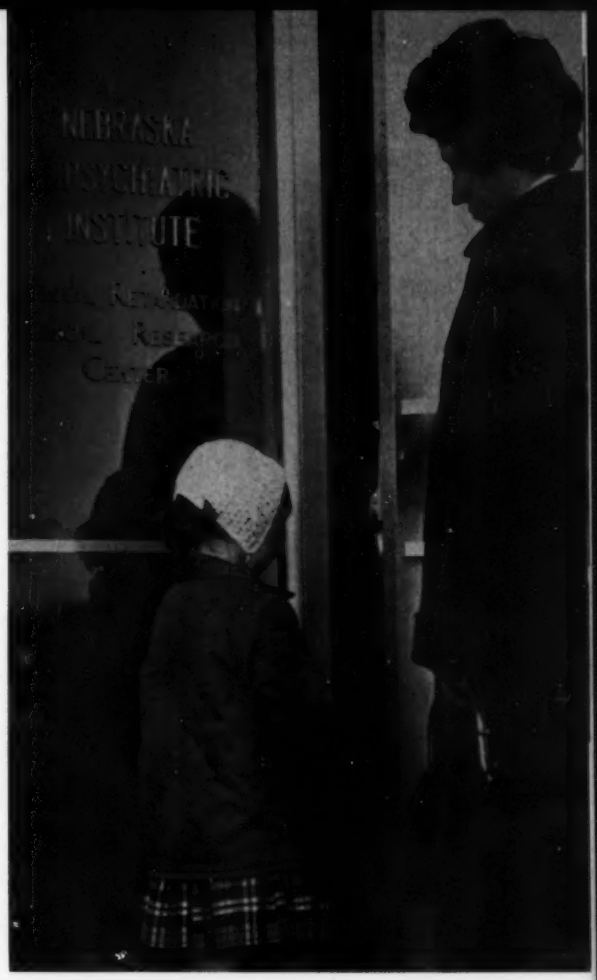
"The scope of the problem and its effect upon us is apparent in the large numbers affected by the condition. Approximately 5 million persons in this country are retarded. It strikes those least able to protect themselves—our children. It affects by its nature their relationships to all members of their families and their friends. Thus, mental retardation is a serious personal matter to at least one out of every twelve people. It disables ten times as many as diabetes, 20 times as many as tuberculosis, 25 times as many as muscular dystrophy, and 600 times as many as infantile paralysis.

"By 1970 . . . we will have at least one million more retarded persons than there are at present. Over half will be children under nine, many of whom will suffer from both physical and mental handicaps. This growth in mental retardation is particularly anomalous in view of the advances in the medical sciences. Deaths at the time of birth have been reduced 75 per cent in 20 years, tuberculosis 30 per cent in five years, and such scourges as whooping cough, diphtheria, and scarlet fever have been almost completely eliminated. But the prevalence of mental retardation has steadily increased. Today, one out of four beds in state institutions is assigned to a mentally retarded person. Nevertheless, all public facilities have long waiting lists. Children needing service cannot obtain it. Our state institutions are overcrowded. The average state hospital has 367 patients more than its rated capacity. Its waiting list numbers 340.

"Many retarded persons never reach a hospital. Their impairment, though mild, is a matter of serious concern. Over 700,000 draftees were rejected as unfit during World War II because they were mentally deficient or illiterate. The number of retarded who could not participate in the war effort was even greater. In many instances, illiteracy and mental retardation are indistinguishable.

"Every year 126,000 babies are born who will be mentally retarded. Neither the rich nor the poor, the urban dweller or the farmer, the captain of industry or the manual laborer, or any other part of our society is exempt from the threat. It is a national problem and it requires a national solution.

"There are no reliable estimates of the cost to each family for the care of the mentally retarded. Community costs of the 4 per cent confined to institutions total approximately $300 million annually. The other 96 per cent live in private homes. The financial



THE NEBRASKA PLAN

The program of the new Mental Retardation Clinical Research Center of the Nebraska Psychiatric Institute constitutes the kind of research effort called for in President Kennedy's program for action against mental retardation.

Established in May 1961 in Omaha, and supported by a $1,745,000 NIMH grant, the Center has initiated a broad, intensive program which strives to catalyze the interest and activities of the many disciplines concerned—permitting full exploration of clinical research directed toward determining the causes of mental retardation, clarifying diagnoses, and

developing useful techniques and procedures for prevention and treatment. A vital simultaneous parallel goal is provision of a setting for training all pertinent disciplines, at undergraduate, graduate, and postgraduate levels.

Staff members will include research psychiatrist; neurologist; pediatrician; neuro-surgeon; clinical, developmental, and experimental psychologists; cyto-

geneticist; population geneticist; medical sociologist; developmental anthropologist; biochemists; psychiatric social workers; speech pathologists; nutritionist; educational therapist; biometrician; tetralogist; and a battalion of technicians.

Now being developed are clinical and research areas totaling about 15,000 square feet. Facilities

strain of providing for them represents a staggering burden to each family that has this responsibility.

"But the financial hardships are not the most serious aspect of the problem. It is the emotional strain, the problems of adjustment, training, schooling, and vocation—the attempt to make possible a full life for the child, that represents the major impact of retardation. Our goal should be to prevent retardation. Failing this, we must provide for the retarded the same opportunity for full social development that is the birthright of every American child.

"In addition to research, the current problems are those of diagnosis, evaluation, care, appropriate training and education, family guidance, the need for sympathetic environment, a lack of public understanding, and a dearth of private and public facilities. There are difficult issues involving not only our social responsibility for adequate care of the retarded, but the extent of the responsibility of the retarded individual himself, as, for example, when he gets into trouble with the law. For a long time we chose to turn away from these problems. The standard treatment consisted of commitment to institutions, segregation from society, and silence about the affliction.

"In this vast reservoir of children and adults who need various degrees of assistance to enable them to adjust to the demands of our complex society, we have a largely unused resource. As society becomes more complex, the problems will of necessity increase both in size and in seriousness.

"It is just as important to integrate the mentally retarded within our modern society and make full use of their abilities as it is to make a special effort to do this for the physically handicapped. The grim struggle for survival does not allow us the luxury of wasting our human resources.

II. Present Programs

"Some forms of mental retardation can be prevented; in others the degree of incapacity can be reduced; and in still others it may be possible to obtain a completely satisfactory adjustment. Steps taken thus far have concentrated upon improvements in environment and understanding. These are important and should be expanded. But real improvement will require a major effort along new lines.

"Prior to 1950 relatively little attention was directed to the problem of mental retardation by either the federal or state governments or, in fact, by private groups. During the past decade, however, increased interest and activity have been stimulated by a few foundations, by the demands of parents, by interested lay and professional groups, and by members of legislative bodies who have been convinced of the urgent need for progress in this field.

"Until 1954, no state health department offered any special services for mentally retarded children or their families. The welfare services were directed largely to long-term institutional care. Today almost

every state has a special demonstration, service, or training project in mental retardation as a part of its maternal and child health service program. Last year the National Institute of Mental Health spent over $2.5 million on research, technical assistance, and grants in the mental retardation area, and the National Institute of Neurological Diseases and Blindness spent over $8 million on mental retardation. Next year's budget requests will double these figures. And the number of mentally retarded persons rehabilitated should also increase.

"Today, the effort to help the mentally retarded takes six basic forms:

"1) Diagnostic and clinical services for the retarded are being expanded. There are over 80 clinics specializing in services to the retarded. Well over half were established within the past five years. These services need still greater expansion. The 20,000 children aided in 1960 represent only a small fraction of those who need the service.

"2) There has been an increase in the beds in residential institutions. Today there are over 200,000 mentally retarded patients in such institutions, approximately 10 per cent more than there were five years ago. But the average waiting list continues to grow, and the quality of the service often suffers from limited budgets and salary levels. In the public institutions, there are less than 500 full-time physicians for 160,000 patients. The limited resources of the State institutions have been taxed beyond the breaking point. Additional increases in both facilities and manpower are necessary.

"3) The number of mentally retarded enrolled in special classes has been doubled over the past decade. In spite of this record, we are not yet meeting our existing requirements, and more such facilities must be provided. Less than 25 per cent of our retarded children have access to special education. Moreover, the classes need teachers specially trained to meet the specialized needs of the retarded. To meet minimum standards, at least 75,000 such teachers are required. Today there are less than 20,000, and many of these have not fully met professional standards.

"4) Parent counseling is now being provided by private physicians, clinic staffs, social workers, nurses, psychologists, and school personnel. Although this service is still in an experimental stage of development, it offers bright prospects for helping parents to meet their social and emotional problems.

"5) Child welfare agencies are attempting to meet some of the needs of the mentally retarded. It is estimated that 10 per cent of the 375,000 children brought to the attention of the agencies through such pathways as neglect, dependency, and delinquency are retarded. The social workers and other personnel tending to the needs of these children should be trained specifically in the area of retardation.

"6) Finally, the preparation of the mentally retarded for a useful role in society and industry must receive more attention. In the past five years the number of mentally retarded rehabilitated through

include a clinical research ward for ten patients separated from other patient areas and containing a metabolic laboratory; by using recent electronic developments, the ward will be able to make recordings and visual and physiological remote observations on a 24-hour basis. Currently in existence or under development are a number of supporting facilitiess psychophysiology, biochemical and EEG laboratories, and specially designed labs for genetics, communicative disorders, and psychology. It appears likely that laboratory space will later be provided for anthropology, biometrics, and tetragenic studies. Supporting laboratories will be established in two state institutions for the retarded. Patients for special study will come primarily, but not exclusively, from Nebraska.

To enable the Center's staff to communicate readily and regularly, at minimum time and expense, with investigators in other countries, 90-minute monthly seminars will be held via special telephone hookup with participating scientists in England and on the continent.

Nebraska Psychiatric Institute's special interest

and activity in retardation first bore fruit in 1958, with the award of an NIMH grant to finance a pilot screening-treatment unit. Outpatient, daypatient, and inpatient facilities and a specially designed psychiatric nursery and laboratory for communicative disorders were provided. Other clinical laboratory facilities at the University of Nebraska and the entire Nebraska Medical Center were made available.

Subsequently developed facilities include an eight-bed neurological research ward, established with regular funds supplemented by state funds; this ward has studied mentally retarded patients with epilepsy, with the aim of rehabilitating long-institutionalized young adults. Current studies are directed toward alleviating symptoms in more severely ill epileptic patients. An anonymous gift provided funds for a research pavilion, and a gift from the Swanson Foundation established a 16-bed children's clinic to study rehabilitative potentials of children with multiple handicaps.

"Our experience in this program convinces us that at present even the cumulative findings of a team of specialists are often insufficient to establish definitive diagnoses in this difficult area," says Cecil Wittson, M.D., director of the Nebraska Psychiatric

state vocational agencies has more than tripled—going from 756 to 2,500—but in terms of potential, it is little more than a gesture. The problem is complex. Neither special education nor special rehabilitation procedures furnish the complete answer to employment of the retarded. New knowledge and new techniques are needed, for over 25 per cent of those coming out of the special classes still cannot be placed.

III. Present Opportunities for New Scientific Solutions

"In terms of the enormity of the challenge, all these efforts represent only a modest approach along limited lines. The central problem remains unsolved, for the cause and treatment of mental retardation are largely untouched. An attack on these questions justifies the talents of our best minds.

"A moon-shot is not possible without prior discoveries in aerodynamics, propulsion physics, astronomy, and other sciences. A successful attack on a complex problem like mental retardation also requires a host of prior achievements, trained scientific personnel, tools and techniques, profound understanding of the behavioral sciences, a spirit of devotion to the underprivileged, and a free, democratic atmosphere of inquiry. Fortunately, ours is a country in which these ingredients abound. Our leadership in these fields is unchallenged.

"Much of the world's population still struggles for mere survival; others for domination of the weaker. Our aim is individual and national dignity. Our fortune is scientific and technological ability. Our obligation is to search for the secrets of the human mind and to share our knowledge throughout the world.

"Discoveries of the wheel, the internal combustion engine, and principles of thermodynamics have liberated mankind from much physical labor. Two hundred years ago man demonstrated, through the discoveries of Lavoisier and Harvey, that human life is governed by universal physical laws. Major progress in science and medicine can be measured from that date. Until the last two decades, however, little research was concentrated on the nature of the living cell and its reproduction. But great strides have been made in that direction through the understanding of the chemical basis of genes and chromosomes and their governing role in life itself.

"The future belongs to those who can carry forward these achievements. It is now possible to attack the causes and prevention, as well as the treatment, of mental retardation. This will require new breakthroughs, but it will pay enormous dividends in knowledge about ourselves, for the functions of the brain represent an almost completely uncharted frontier. The basic research entailed in such an effort will probe the essence of human development, and its results may far exceed its objectives. Exploration and discovery in this field may uncover the secrets of life and man's capacities, and the answers to many mysteries of social behavior. Perhaps even more im-

portant, an understanding for the motivation and effect of human behavior offers the hope of fostering the rational behavior of nations.

"Progress in the natural sciences during the past 15 years has been impressive, but achievements in the prevention and therapy of mental retardation can be even more spectacular and can bring important benefits to mankind.

IV. The Task of the Panel

"We must undertake a comprehensive and coordinated attack on the problem of mental retardation. The large number of people involved, the great cost to the nation, the striking need, the vast area of the unknown that beckons us to increased research efforts—all demand attention.

"It is for that reason that I am calling together a panel of outstanding physicians, scientists, educators, lawyers, psychologists, social scientists, and leaders in this field to prescribe the program of action. I am sure that the talent which has led to progress in other fields of medicine and the physical sciences can enlarge the frontiers of this largely ignored area.

"It shall be the responsibility of this panel to explore the possibilities and pathways to prevent and cure mental retardation. No relevant discipline and no fact that will help achieve this goal is to be neglected.

"The panel will also make a broad study of the scope and dimensions of the various factors that are relevant to mental retardation. These include biological, psychological, educational, vocational, and socio-cultural aspects of the condition and their impact upon each state of development—marriage, pregnancy, delivery, childhood, and adulthood.

"The panel will also appraise the adequacy of existing programs and the possibilities for greater utilization of current knowledge. There are already many devoted workers in this field, trained in diagnosis, treatment, care, education, and rehabilitation. The panel should ascertain the gaps in programs and any failure in coordination of activities.

"The panel will review and make recommendations with regard to:

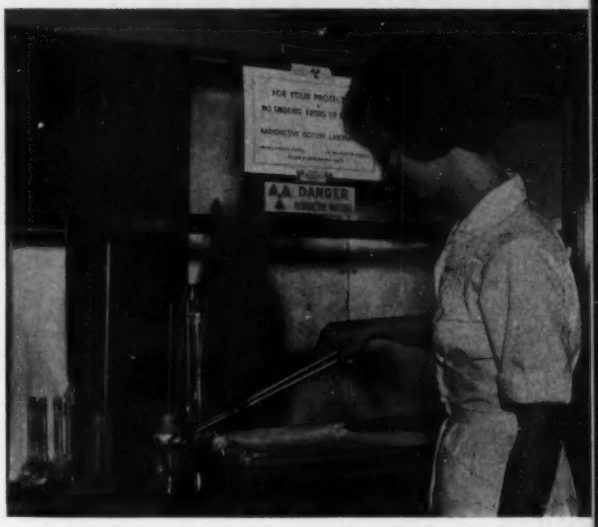
"1) The personnel necessary to develop and apply the new knowledge. The present shortage of personnel is a major problem in our logistics. More physicians, nurses, social workers, educators, psychologists, and other trained workers are needed.

"2) The major areas of concern that offer the most hope; and the means, the techniques, and the private and governmental structures necessary to encourage research in these areas.

"3) The present programs of treatment, education, and rehabilitation.

"4) The relationships between the federal government, the states, and private resources in their common efforts to eliminate mental retardation.

"I am asking the panel to report on or before December 31, 1962."



Institute. "Additionally, we believe that early diagnosis and suitable facilities can make it possible to treat many children successfully—children who otherwise would be destined for years of institutionalization."

Investigations now in progress or planned for the near future include basic studies in mongolism; development and refinement of biochemical techniques as a screening procedure for mental retardation; social and cultural determinants; improved procedures for differentiating between retardation and other psychiatric conditions in children; double and multiple handicaps in the retarded; communicative disorders; identification and treatment of babies with reversible retardation caused by emotional deprivation; effects of dietary inadequacy on mental development; psychotherapeutic techniques for the retarded; causes of developmental defects; and developmental enzymology.

This broad range of research, and the wide range of disciplines participating in it, constitute an action program whose results may exceed even its long-range objectives. The Nebraska Plan bears witness to how very much can be accomplished by a state facility which determines to meet the challenge of retardation energetically and head on.

Number Eight in a Series by Past Presidents of APA

Implications of Goals of Therapy

BY R. H. FELIX, M.D. (1960-1961)
Director, National Institute for Mental Health
Bethesda, Md.

IN ANY PSYCHIATRIC SITUATION, a central question faces us: "What are the treatment goals for this patient?" The goals we choose in each case have far-reaching program implications; they are based as much upon our concept of our role vis-a-vis our patient as upon our assessment of his case.

As physicians we cannot delegate the decision of what our goals will be to other members of the treatment team or to the demands of society. It is one decision that must always remain ours alone. This problem and its ramifications have puzzled and preoccupied me for some time, and I am grateful to have the opportunity to discuss them here.

I would like to review some of the factors we must consider when we make this decision and to suggest possible approaches that will result in more effective, realistic, appropriate treatment techniques and program goals. In the light of new therapeutic techniques and treatment developments, and our new understandings of human behavior, it is time for us to reconsider a psychiatrist's responsibilities in determining goals of therapy.

We must also examine both the overt and covert aspects of our decisions and become aware of the personal attitudes, beliefs, and opinions that influence our determination of goals. We must each ask ourselves, "To what extent do attitudes developed as a result of my training and experience, as opposed to the findings in this case, determine my choice of goals?" And, "Is my adherence to a particular theoretical framework so rigid that I have less than optimum flexibility in exercising my capabilities as a physician?"

First, a psychiatrist must take into account the range of possible treatment goals. I can think of at least eight and have no doubt that there are others. As I see it, the goals of therapy can be:

1) Deep and extensive exploration and reorganization of the patient's personality.
2) The amelioration and/or removal of the patient's disabling symptoms.
3) Providing the patient with needed counsel and emotional support.
4) Assisting the patient to achieve an adequate social and occupational adjustment.
5) Assisting the patient to achieve the degree of personal composure that is necessary for coping with everyday life.
6) Helping the patient to adequately handle a crisis in his life.
7) Giving the patient the comprehensive care and social protection his condition requires.
8) Working toward a combination of the goals listed above.

Each of these goals and every possible combination of them might be appropriate clinically and socially for some patients. However, in determining the appropriateness of a treatment goal, a psychiatrist considers a second group of factors—the patient's life situation and the nature of his illness. In many instances, consideration of these two factors alone will determine therapy goals. A depression in a middle-aged man may call for "removal of the patient's disabling symptoms." A bereavement situation may call for "helping the patient to adequately handle this crisis in his life." For other patients, the goal of "deep and extensive exploration and reorganization of the patient's personality" may be appropriate.

For hundreds of thousands of our patients, however, a third set of factors, concerning the number and kind of available psychiatrists and psychiatric personnel, is of critical importance.

At present there are not enough psychiatric personnel to meet the country's minimum needs on the "old line" programs, to say nothing of the newer programs and problem areas. In some parts of the country, such personnel are so scarce as to be practically nonexistent. In several specialized psychiatric fields (for example, industrial psychiatry, alcoholism, school mental health programs) psychiatric personnel are unavailable for many patients needing help. As more personnel become available, the demand increases, hence the wide gap between supply and demand.

What are the program and treatment implications of these realities? In many areas of the United States patients seeking extramural psychotherapy cannot ob-

tain it immediately. This delay is brought about partly because many psychiatrists are fully occupied by relatively few patients in long-term therapy. I do not question the suitability of this goal for selected patients, but I am concerned lest it be chosen indiscriminately, valued inordinately, resulting in a tendency on the part of too many psychiatrists to "select into" their patient-load only patients who fit this goal.

The result of indiscriminate choice of this goal is suggested in a recent study which revealed that the most common notation on closing out a case was that the "patient failed to return." In other words, the patient was through with treatment before the psychiatrist was. For some, this disinclination to return was caused by lack of time, money, transportation, or even babysitters. Others, of course, probably did not return because of intrapsychic factors. But I believe there is another group who did not return because they: (1) decided to find another source of help, or (2) had obtained what they came for, that is, relief of the symptoms which made them seek treatment.

There is additional evidence that some treatment programs do not function optimally to meet either the patient's or the public's needs. Many patients who need help never present themselves for treatment, believing either that they cannot secure an appointment or cannot devote the time and funds they think will be required. Others, for the same reasons, turn for assistance to resources that cannot or do not discriminate between the persons they can help and those who should be referred to those who possess the necessary skills.

The Need for Public Support

Dysfunction of psychiatric programs can also be due to difficulties in obtaining public support, financial or otherwise. Among the reasons given for this nonsupport are: "The waiting list is so long that persons needing help immediately have little chance of getting it." Or, "The number of people who receive psychiatric help is so much smaller than the backlog of those needing help from other medical programs that I would prefer to give my money to help activities of the latter type."

What has been said about the dysfunctions of our extramural programs is paralleled by the dysfunctions of our intramural programs: there are too many patients; it is difficult to get adequate public support for our hospital programs; and, by and large, many patients don't get the help they need.

We are faced, then, with a curious dichotomy. On the one hand, many persons who need, would like, and could benefit from psychotherapy are deterred by the scarcity of personnel from seeking treatment; and, on the other hand, many patients who see a psychiatrist or who enter treatment stop before the psychiatrist's therapeutic goal has been reached.

If we were dealing with material products rather than with psychiatric therapy and care, I venture to say that most economists would apply Gresham's Law: if two products are available, one cheap and the other expensive, the cheaper, if available in an adequate amount, will supplant the more expensive regardless of relative quality. And this is one of my concerns. There is a demand for more psychotherapy than we can provide; at the same time, we have not sufficiently concerned ourselves with devising effective modifications to meet the needs and demands of our communities.

Second Thoughts about Depth Therapy

These realities concerning our present programs reinforce my belief that some readjustment of our thinking about goals is in order. Should the chosen treatment for a substantial number of our patients continue to be "deep and extensive exploration and reorganization"? Is this, the "ideal" goal—the one many of us have been trained to use—still the best goal for many patients? Are the techniques we use in achieving this goal still the best techniques?

In short, should we continue to place so much emphasis on the importance of individual therapeutic relationships when these relationships traditionally demand a 50-minute hour spent with only one patient, and when many persons needing help could be benefited from modification of this arrangement?

Another factor impinging upon a psychiatrist as he determines treatment goals is his training—and the theoretical concepts underlying his training. Here, I think, we have two additional problems:

1) In teaching programs there is inadequate emphasis on the psychoses and on treatment in hospital settings; this produces personnel who are disinclined to treat the more grave emotional disorders, and, therefore, tend to limit their practice to persons who can be seen as outpatients.
2) The models and curricula of many training programs do not motivate young psychiatrists to work in some of our most needed areas.

I have considerable evidence to support the thesis that many of our psychiatric training programs unduly restrict our choice of treatment goals and programs. At the National Institute of Mental Health, for example, we continually receive complaints from directors of state mental health and hospital programs about graduates of many psychiatric centers who are ill prepared to deal with the psychoses or community aspects of hospital programs. These graduates do not know how or when to use community agencies.

In one recently established emergency psychiatric clinic, the supervising psychiatrists found that the third year residents, who were called upon to treat "walk-ins" and see patients for only a few sessions, were extremely uneasy in this role. Part of this uneasiness—which was not founded on lack of experience—was caused by the residents' "in-trained" belief that brief therapy was not valuable, was actually detrimental, and was bad psychiatry. Brief therapy had no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From the Literature

Excitement Following Electroconvulsive Therapy

Murray[1] administered parenteral SPARINE (with atropine sulfate, succinylcholine dichloride, and a barbiturate) to 50 patients prior to electronconvulsive therapy. Observations were conducted during 497 individual treatments.

The salutary effects of SPARINE, which Murray attributes to enhancement of barbiturate action, were evident in improved behavior, diminution of agitation following treatment, and prolongation of sleep. No significant blood pressure fluctuations or cardiovascular abnormalities were noted in any of the patients.

Excessive Psychokinetic Activity

Graffeo[2] selected 180 chronic, hospitalized psychotic patients at random on the basis of increased psychokinetic activity manifested by restlessness and agitation, or complications or lack of improvement with other chemotherapeutic modalities.

SPARINE was administered orally in dosages graded to the psychokinetic activity of the patient.

Of the 180 patients, 72 percent showed marked to moderate improvement in behavior, and no patient's behavior worsened. Almost half of the patients showed marked to moderate improvement in their psychoses; in 3 percent mild regressive tendencies were noted. According to the author: "Promazine [SPARINE] adequately modified the formerly disturbed behavior pattern of the chronic schizophrenic patients so that psychotherapy was facilitated and, as a result, made it possible for 26 patients to be released from the hospital."

Alcoholism

Figurelli[3] has found that the use of SPARINE in uncomplicated cases of acute alcoholism controlled symptoms of active delirium, as well as nausea and vomiting, and drastically reduced mortality rates. According to Figurelli ". . . medication with promazine [SPARINE] enables more rapid control of delirium, eliminates the prolonged and more expensive therapeutic measures which formerly were the only recourse . . . and permits earlier return of the patient to gainful occupation." Parenteral SPARINE is usually used initially by Figurelli; oral SPARINE is used for maintenance. No precipitous drop in blood pressure occurred in the series of patients studied by Figurelli.

Note: The degree of central nervous system depression induced by SPARINE has not been great; however, in the acutely inebriated person the initial dose should not exceed that recommended to be sure that the depressant effect of alcohol is not enhanced. SPARINE should not be used in comatose states due to central nervous system depressants (alcohol, barbiturates, opiates, etc.). In patients with cerebral arteriosclerosis, coronary heart disease, or other conditions where a drop in blood pressure may be undesirable, SPARINE should be used with caution.

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1. Murray, N.: Diseases of Nervous System *21*:1 (Aug.) 1960.
2. Graffeo, A.J.: Am. J. Psychiat. *116*:842 (March) 1960.
3. Figurelli, F.A.: J. Am. Med. Assoc. *166*:747 (Feb. 15) 1958.

For further information on limitations, administration and prescribing of SPARINE, see descriptive literature or current Direction Circular.

place in their concepts of what a good psychiatrist does for his patients.

Additional clues implying the rigidities of our training programs may be found by following reports of what are considered to be new and unique experiments in training. I can recall the following reports on "unique" training programs of recent years: (1) the use of residents in emergency clinics where the patient sees the psychiatrist without an appointment and without prior "work-up" by a clinic team; (2) the use of residents in community programs, each assigned for one or two days a month to work with health officers located in areas apart from the training institution; (3) in prehospitalization screening programs, having supervised residents, as well as social workers, visit the homes of potential patients; (4) the use of medical students and residents in preventive family care programs in which the students or residents are assigned to a family to follow and to treat family members, if need be, for a number of years; (5) the use of residents in nonpsychiatric services of general hospitals, with the thought that they should become acquainted with and contribute to the treatment of the emotional components of physical illnesses. In many cases such activities are considered to be new and daring departures, although they actually are not unique.

Indications for a New Philosophy

I am more and more convinced that the public is going to demand and obtain help somewhere for emotional problems. Therefore, I would like to suggest techniques and areas of need that we should explore and develop. However, new techniques and responses to the problems confronting us can only develop optimally from a philosophy which differs from that underlying current treatment goals in many centers.

In appropriate cases we can make more effective use of shorter therapeutic sessions. It would be interesting and possibly profitable to experiment further and in greater depth with a combination of group therapy and shorter sessions. Either of these techniques, and certainly this combination, calls for highly developed clinical and therapeutic skills; they should not be used by novices, except under close supervision in a training situation.

We must concentrate on developing the skills of associated personnel and learn how these skills may be used for maximum effectiveness. We can give residents an image of the community as a part of the treatment armamentarium and train them in the therapeutic use of the community's resources as a supplement to traditional forms of therapy.

We can develop, on a vastly extended scale, the concept of the emergency psychiatric service and learn how it can be adapted to meet community needs. We can explore, deliberately and intensively, the possibilities of providing short-term counseling services in various settings for persons in the early stages of mental illness and for a number of specific purposes: school counseling and guidance programs; pastoral counseling; programs of counseling and guidance in industries; marriage counseling. We can indicate to our residents that it is professionally meritorious to acquire skills in short-term therapy and to remain flexible about goals.

We can intensify our efforts to provide alternatives to hospitalization. We already have made considerable progress in this direction by using new pharmacologic agents and increasingly accepting the values accruing from the open hospital, day-and-night-care programs, foster home programs, etc.

Therapy for the Aged and Chronically Ill

While we are experimenting with new techniques in the intramural and extramural treatment of patients, we will also have the opportunity—given some flexibility of therapeutic goals—to work toward filling the needs of patients who require something other than traditional therapy. For example, the process of adjusting to old age, which demands a change in roles and in self-perception, is difficult for a number of persons who have successfully met the challenges of other life experiences. They need support and the opportunity to ventilate—yet training programs reflect little concern with the psychotherapy of the aging, and many psychiatrists show little interest in working with the aging in a therapeutic relationship.

Another group of patients whose needs are unmet by our current techniques and programs are the chronically ill, many of whom have difficulty in securing proper psychiatric assistance in coping with the emotional components of their illnesses. This group's problems are complicated because there are several kinds of chronically ill patients, each requiring a different therapeutic approach: (1) those who have experienced the sudden onset of a more or less permanent disability; for example, a traumatic amputation or blindness; (2) those who are experiencing the acute phase of an illness that will result in subsequent disability, but little threat to life; for example, arthritis; (3) those who are experiencing the onset of an illness that carries with it subsequent disability and the probability of recurring attacks and death; for example, multiple sclerosis. There are other illnesses that create special emotional vulnerabilities for their victims: diabetes, cancer, tuberculosis, and cerebral palsy.

In addition, we should concern ourselves with the special problems and needs of the doomed or dying patient and his family, the bereaved, and the emotionally upset, as well as with the tremendous challenge posed by the retarded, the aged, and the alcoholic, among others. Certainly we cannot do all of these things, even in a token way, unless we can find more time in an already overcrowded day; at least we can do *some* of them if we develop techniques that permit us to use our time and talents more effectively.

Cutting across all of these patient groups are the cleavages and challenges raised by the problems of social class. The Hollingshead and Redlich study in

New Haven and other studies in Salt Lake City and Los Angeles reveal that, if we are going to meet the needs of many of our patients—our so-called "lower-class" patients—we must develop new approaches to their problems. The central message of these new sociological studies is that the upper-middle-class psychiatrist has difficulty in communicating with or even understanding his lower-class patient; and the lower-class patient, with his special needs and illnesses, finds it difficult to benefit from traditional psychotherapy.

Meeting these needs, using these social insights, and developing new techniques would mean that we had adopted the *primary* therapeutic goal of all good medicine: to assist the patient's return to social usefulness. I believe the deliberate choice of this goal as the *primary* goal is worth our deepest consideration. As a matter of fact, we all know that return to social usefulness is therapeutic in and of itself.

Feasibility of the "Ideal Goal"

The complete amelioration of all pathological factors in our patients is, of course, the ideal goal; however, there are many instances when its achievement is not feasible. I want to make it quite clear, however, that I am not advocating the abandonment of the "one-to-one" relationship or of deep therapy as *one* appropriate goal. Nor am I advocating that psychiatrists abandon either learning or practicing the deeper techniques we are all taught. I think it is important that deep psychotherapy be developed both as a technique and as an individual skill and that all psychiatrists be competent in this modality. I am aware, too, that many patients cannot be returned to duty except through a prolonged experience of deep psychotherapy and that, following a return to social usefulness, many patients may achieve a more complete and lasting recovery with the long-term assistance of a skillful psychotherapist.

What I am asking is that we examine the program implications of our traditional emphasis upon deep, long-term therapy as the ideal goal. I request that we review the program implications of employing the "fifty-minute" hour, and the "one-to-one" relationship for every patient. And I am wondering whether the time has not arrived when we should, without feeling guilty, state that our primary goal—though not our only goal—is to return as many of our patients as possible to social usefulness.

I believe the time has arrived when it is appropriate, feasible, and necessary for us to do this. We have achieved such a level of professional skill and medical knowledge that it is possible for us, realistically, to adopt this primary goal. We have new knowledge. We have new treatment teachniques. We have new colleagues, professionally trained, to assist us. The public and our patients are demanding that we increase the effectiveness of what are, admittedly, herculean efforts.

Further, I believe that this change in emphasis has already occurred in the contemporary practice of psychiatry. Most of us have faced our professional problems realistically and have appraised our social roles with enough humility to recognize the limitations of some of our time-honored practices.

I believe this change in emphasis and this choice should be dignified by our acknowledgement of its having occurred. I believe we should increase our efforts to speed the day when, for most of American psychiatry, the goal of "return to social usefulness" is the acknowledged, primary goal of therapy for most of our patients.

Some Principles for Therapeutic Goals

It is my belief that as physicians, as scientifically trained individuals, as people concerned with making possible the most good for the most people, and as compassionate human beings, we should observe the following principles in our choice of therapeutic goals for individual patients and program goals for our states and communities.

1) The primary objective of the psychiatrist must be to return the patient to a productive social role. Other objectives must be subordinate to this.

2) To be truly available to a community or to individual patients, psychiatric services must cost no more than the community or the patients can afford to pay.

3) Since, as a general rule, the earlier the treatment in the course of a mental disorder the better, programs that include the essential element of ready availability of psychiatrists must be set up and administered to encourage and to make possible the early presentation of a patient for treatment.

4) Intramural and extramural treatment should not be considered as separate entities but as different constellations of techniques that are appropriate for different phases of the same clinical phenomenon. Good medical practice requires training in and professional experience with both office and institutional practice in order to reduce to a minimum the hazard of a break in the therapeutic relationship.

5) The psychiatrist, in assisting the patient, should increase the effectiveness of his own professional contributions by encouraging persons in other professional disciplines to work with him and to make their maximum contributions to the patient's treatment program.

Underlying all of these principles, as we reach out in our thinking and practice to help the most people, should be the state of mind and heart embodied in the concluding paragraph of the daily prayer of Maimonides, a 12th century physician:

> May there never rise in me the notion that I know enough, but give me strength and leisure and zeal to enlarge my knowledge. Our work is great, and the mind of man presses forward forever. Thou hast chosen me in Thy grace, to watch over the life and death of Thy creatures. I am about to fulfill my duties. Guide me in this immense work so that it may be of avail. •

Notes on the 6th International Congress on Mental Health

Paris, France, August 30-September 5, 1961

By WALTER E. BARTON, M.D.
President, American Psychiatric Association
Superintendent, Boston State Hospital

THE BEST LAID PLANS OF PSYCHIATRISTS traveling to conferences can go awry as easily as those of any tourist bound for two weeks of Venetian gondola rides or pub-crawling in England. Nothing serious, mind you—merely the failure of Idlewild's bus service on August 27th, the day of my departure—and the disappearance of my bag containing documents, clothing, shaving equipment, and various other materials.

Once aloft, I struggled with the problems of sleeping more or less vertically and how to comfortably accommodate two meals in five hours. I managed to eat successfully, but not to sleep, so I had time to muse upon the excellence of KLM's terminal facilities and to anticipate my arrival in Amsterdam.

On the ground once more, I was soothed by two solicitous and most attractive young ladies, assigned to see to my comfort, who set about tracing my lost luggage. I had time to enjoy shopping and sightseeing, an interesting tour through the Excerpta Medica headquarters, and a good dinner with good friends.

Then I went on to Haarlem and a beach hotel reminiscent of its cousins in Virginia Beach. There, Dr. Morris Fishbein recorded an interview with me for subscribers to the "Voice of Medicine" series.

Congress Attracts 1,000 Delegates

The next day, I was one of 1,000 persons who had come from all parts of the world to attend the Congress at the Sorbonne in Paris. At our first meeting, we were welcomed by Professor Paul Sivadon (France), chairman of the Organizing Committee and a man with extraordinary energy. He commutes between Paris and Brussels to head teaching activities in both capitals and has time to direct the planning and construction of 20 new hospitals.

The Congress was the concluding event of World Mental Health Year (officially observed in 1960) and focused its presentations on the following themes: the needs of children and youth; national surveys in the fields of mental health and ill health; teaching the principles of mental health; and mental health as it relates to the sociological aspects of industrial change, migrations, and old age.

There were many speakers, and I am reluctant to forego remarks about any of them, but discrimination is an obvious necessity in a report of this kind. Therefore, I will restrict my comments about the speakers to those who delivered messages that I think will be of especial interest to readers of *Mental Hospitals*.

Progress Report from the French

M. Bernard Chenot, France's Minister of Public Health and Population, reminded the delegates that, although France exercised leadership in psychiatry for 100 years after Pinel, psychiatric advances after 1900 did not parallel progress in the other sciences. World War II found French psychiatry at its lowest ebb, but later, EST, the discovery of Largactil by Denniker and Delay, and Sivadon's readaptation therapy restored hope and energy. Today, one third of all money set aside for hospital development in France is going into mental hospitals. Twenty new 300-bed mental hospitals are under construction; modernization of old buildings is progressing rapidly, and there are many new approaches to therapy. Between 1961 and 1963, day hospitals, aftercare, nursing staffs, and regional planning will become realities in depth.

Professor A. Repond (Switzerland) delivered a humorous, puckish presentation on "Mental Health of Aging," beginning with a significant statistic—27 per cent of the Swiss are over 65. Senescence, he said, starts off "epigenetically" like menstruation and is recognized when gratification of usual pleasures disappears. Professor Repond believes that every effort should be made to keep the elderly in touch with reality, to preserve their family units, and to maintain their contacts with the opposite sex. He condemned separation and segregation as therapeutic measures.

As parting advice, he recommended that a man should always die before his wife because, if it is the other way around, the widower will fall in love with an "evil" woman who will waste his children's rightful inheritance.

Mrs. Susan H. Kubie (U. S.) deplored the stereotype of the aging person—a socially useless individual, progressively deteriorating mentally and physically. Israel's Minister of Health, Dr. Louis Miller, elaborated on this problem in his own country where those who are building a vigorous, young culture consider a man of 50 to be old and unemployable. Israel settles its elderly citizens in 400 villages where they are provided with special housing, social clubs, national insurance coverage, employment, and a full range of health and welfare services. There is one psychiatric ward in a general hospital of 70 beds which serves the entire country. In three years, the ward has served 484 patients and has a 50 per cent discharge rate.

A Spanish Viewpoint

During his talk on the "Cultural Aspects of Mental Health," Professor Ramon Sarro (Spain) presented some provocative thoughts. In essence, they were:

- The world is becoming overpopulated, and when the masses are in control, primitive instincts re-emerge. This is associated with a marked loss of religious feeling.
- Psychoanalysis (as represented by Fromm and Reichmann) devalues man. Fromm, in *Sane Society*, speaks of man as alienated and inclined to overconform to social forces. Man's work is devoid of satisfactions; he lacks individual liberty and blindly follows what advisers and advertisers tell him. Man qualifies his experience; when he travels around the world, he speaks of it in measured miles, numbers of hours, and the kinds of planes he used. He verbalizes, but has no opinions of his own.
- Man today is presented as stupid. On television, father is portrayed as a lovable, bumbling jerk.
- The concept of mental health that stresses the enjoyment of full physical, mental, and social well-being is an ideal; no one qualifies to meet it. A more favorable concept, from the medical point of view, is the "absence of illness." The instrumental values of mental health are inferior to moral ones.
- There is a crisis in psychoanalysis. Its therapeutic power is zero; a four-year comparative study showed that patients who received it as therapy gained no advantages over those who received other treatment forms. Psychoanalysis once had value, but lost it when its secrets became known and the public shared the analyst's knowledge.
- Man is undergoing transformation; a new individual and a new style of life are emerging. This new man will not be a superman of the Nietzsche type—just a better man.

The Right Honorable P. J. Noel-Baker, Member of Parliament, United Kingdom, and winner of the 1959 Nobel Peace Prize, spoke on the "Psychological Dangers to World Peace." He reviewed the implications of the arms race, mentioning worldwide revulsion when poison gas was first used and pointing out that now, 46 years later, all responsible leaders would not hesitate to use the H bomb if "necessity" demanded it. This, he said, is an astonishing psychological transition in public opinion to have occurred in less than half a century. Noel-Baker believes that doctors should cry out against the perversion of science and medicine.

According to Professor Ben Morris (United Kingdom), there is little value in having the future psychiatrist acquire an intellectual command of "the shibboleths of psychodynamics" if he himself remains insensitive and defensive toward the large range of human feelings. People can be helped significantly only when they are enabled to help themselves. In helping others, the student must imaginatively enter into their situations. This makes demands on him as a person and removes him altogether from the role of manipulator or arranger. Professor Morris said that there are four central concepts with which the student must come to terms: (1) the ubiquitous nature of unconscious processes; (2) the persistent effects of previous (particularly early) experiences in later life; (3) the coexistence and dominating influences of love and hate; and (4) the protean character of the defensive maneuvers that the ego can call to its aid.

Maria Pfister of the World Health Organization spoke of the need to strengthen the National Health Services—particularly by training and demonstration projects—to meet emergency needs. She explained that, through WHO, 70 experts representing 35 countries form a psychiatric panel and are able to exchange information. Their principal areas of concern are epidemiology, uniform classification, and research; training, particularly of the family doctor and public health officer; integration of mental health and public health efforts; child and family guidance; and public education.

A Quality Film Program

The film program was especially interesting. "The Mental Health Year," produced in the United States by the Mental Health Film Board under the direction of Dr. M. Ralph Kaufman and Mrs. Alberta Jacoby, was well received. It has superb sections that could be cut for use in this country.

An intriguing film, "Uprootedness," was shown to the assemblage. It was prepared by Professor J. Delay (France) and illustrates the dissolution of the art form when an artist acquires schizophrenia. A fascinating example shows the artist's self-portrayal, done before his illness, as a cat with very piercing eyes. As he became ill, the backgrounds of all self-portraits dissolved into an intricate Persian-type design; then the figure and finally the face disappeared. Only the eyes were left, but eventually, they, too, became indistinguishable. In nearly all of the film's portraits by schizophrenic artists shown in the film, the background was the first to dissolve, then the figures and features. As

recovery occurred, the features became recognizable before the background.

Another film, in excellent color, produced by J. A. R. Bickford (United Kingdom), portrayed the rehabilitation of long-stay mental patients. Chronic schizophrenics were shown in work situations, directed by nurses acting as rehabilitation therapists. The film demonstrated how nurses could be used to carry out the programs without the need for additional money or elaborate facilities.

New Officials Installed

During the business session of the Congress, Dr. George S. Stevenson (U. S.) was installed as president. The new president-elect is Dr. Phon Sangsingkeo (Taiwan), and Dr. Francis Cloutier (Canada) was appointed to be the new director of the World Federation of Mental Health, replacing internationally known Dr. Jack Rees, who is retiring.

It is good to be able to report that the World Federation is now soundly financed. Its next meeting will be held in August 1962 in Lima, Peru.

In closing the Congress, Professor Sivadon spoke hopefully of a world community built upon the relationships between people. Man's movement toward interdependence, he said, requires that he assume responsibility for himself and demonstrate responsible action toward others.

The conference widened every participant's understanding of shared problems and of a commonality in objectives. The workshop sections, held each afternoon, brought one into intimate contact with dedicated research workers reporting studies in progress. Field trips to hospitals and clinics gave convincing evidence that new approaches to old problems could be found. The evening social occasions included a night at Versailles after a banquet in the Orangery, and a night at the ballet to see Jeanmaire.

I particularly enjoyed the opportunity to chat informally with Drs. T. P. Rees of England, S. Follin of Ville Evrard, and Paul Sivadon. Professor Silva of Brazil and Dr. Carebedo of Peru expressed genuine interest in developing some more effective methods of cooperation between the American Psychiatric Association and South American psychiatrists. •

The Potent Eunuch

By Dr. WHATSISNAME

The operating machinery of the hospital is there for all to see. The contributions of nurses, attendants, clerks, gardeners, and cooks are seen by even the most casual visitor. The fruits of their labors are obvious.

Totally invisible, however, is the work of administration. Leadership does not usually lend itself well to display. It is sensed rather than seen. The superintendent has to use people as his instruments, his objective being to provide a climate in which they can do their work well. The links from his office to the work in the ward, kitchen, or grounds form an invisible chain. In a sense he is impotent because he is utterly dependent on the achievements of hundreds of other employees.

It is right that those on the front lines receive credit for what they do—watching over patients, pulling files, carrying food, pouring medication, planting shrubs. And if the fruits of the superintendent's labors are not so obvious, he does at least enjoy the lion's share of material rewards such as pay, power, and prestige.

To the patient, to the visitor, to the employees, the superintendent is a czar. But he knows that he is in reality a eunuch, the prisoner of his own personnel. Somehow he must start a ferment in the minds of hundreds of employees. Eunuch he may be—but he is a potent eunuch who can beget enthusiasm and dedication in his staff.

District Branch News

District Branches and MHS Awards

On page 24 of this issue is the announcement of the 1962 Mental Hospital Service Achievement Awards contest. Once again, the Committee, with approval of the Speaker of the Assembly, is requesting local District Branches to make site visits to all facilities submitting applications.

The 1961 Awards Committee profited greatly from the ready and rewarding responses of all the District Branches approached. So enthusiastic were the members that all but two out of 15 Branches met the deadline, and the latecomers were not too tardy for their reports to be of value. The pertinent information supplied influenced the final decisions made by the Awards Committee. Most gratifying were comments made by some respondents that the request gave them a good excuse to go to mental hospitals which they had not visited in many years.

Stewart T. Ginsberg, chairman of the 1962 Awards Committee, earnestly hopes that the District Branches will repeat this enthusiastic response when they receive their copies of local applications.

Connecticut—*Confidentiality for Psychiatric Records*

The Connecticut Legislature has passed a bill providing full confidentiality for psychiatric records and the governor has signed it. William B. Terhune, M.D., largely responsible for promoting the bill, received the support of the State Medical Society, the Connecticut District Branch, and the Connecticut Society for Mental Hygiene. He wrote an editorial that appeared in the *Connecticut Journal of Medicine* and mailed a copy to every doctor in the state, giving him the number of the bill, and asking him to speak personally to his representative or senator. Dr. Terhune also personally appeared before the state legislature.

Kansas—*Proposed Amendment to Constitution*

The Council of the Kansas Psychiatric Society has proposed a constitutional amendment to allow election of members by mail ballot. Applications for membership now are received and examined by the Membership Committee and then presented to the Council. Following approval by the Council, the names of applicants are circularized to the members, and applicants are elected to membership at a regular meeting of the Society. This procedure delays applications because of the infrequency of Council and Society meetings. The proposed amendment would allow election to membership by an affirmative vote of two thirds of the members present and voting at a regular meeting or by the affirmative vote of two thirds of the members responding to mail ballot.

California—*Recommendations on Narcotics Bills*

The Committee on Therapy of the Northern California Psychiatric Society has made recommendations to the Society concerning narcotics bills which have been introduced in the California Legislature. The bills are of three basic types: (1) greater penalties for narcotic addicts; (2) increased police power in addiction cases; and (3) treatment and rehabilitation of addicts.

The Committee recommended that the Society oppose the increased-penalty bills, but strongly support those on treatment and rehabilitation. Committee members concurred that it would be unwise for the Society to directly intervene in the proposals to increase police power since such legislation does not directly relate to the objectives and functions of psychiatry. The Committee, however, considered increased police powers unnecessary and unwise.

—*Liaison with Probation Departments*

The Los Angeles County Probation Department frequently needs to refer children, and occasionally adults, for treatment by psychiatrists in private practice. The department has experienced some difficulty in locating services, partly due to a shortage of psychiatrists in certain areas and partly due to inadequate communication from the psychiatric profession regarding available private services. The Southern California Psychiatric Society is attempting to work out means whereby information can be transmitted to the probation department regarding the society members who are willing to accept such referrals.

New Jersey—*Ninth Annual Psychiatric Institute*

The N. J. District Branch in conjunction with the N. J. Neuro-Psychiatric Institute and the N. J. Neuropsychiatric Association sponsored an institute on the theme, "Stress." The papers read were entitled "Stress and Pain," "Stress and its Relationship to Headache," "Stress Involved in the Grief Process," and "Stress and Experimental Neuroses in Animals in Relation to Human Neuroses and Prejudices." Walter E. Barton, M.D., president of the APA, presided at the one-day session.

Pictures posed by Board members and friends.

Resembling a typical boardinghouse, Rutland Corner House affords a bridge from hospital to home.

Domestic "KP" can be fun with a companion.

A Halfway House

A group of girls drinks coffee, washes and irons the small things, and chats as in a college dormitory.

Mealtimes are fun times, with pleasant linen, china, and chat. Claire Gomness, director, is at the head of the table.

RUTLAND CORNER HOUSE, an unpretentious three-story building near one of the busiest thoroughfares leading into Boston, is licensed as a boarding-house. Few of its neighbors realize that the nine women who live there formerly were patients at the Massachusetts Mental Health Center, located just across the street.

Since its establishment as a halfway house in 1954, Rutland Corner House has handled 98 ex-patients. To date, all but one have come from the mental health center, but the house now offers its services to other psychiatric hospitals in the city.

The professional staff of the mental health center provide psychiatric consultation for the girls when necessary and also maintain a good working relationship with the director of the house, Miss Claire Gomness, and the assistant director and housekeeper, Mrs. Gertrude Goldsmith. Sometimes a student psychiatric social worker is added to the staff, working part-time and "living-in" with the other residents. A janitor does the heavy chores.

Before admission, the prognosis and background of a prospective resident is discussed by an admission-discharge committee, composed of staff members of the mental health center and members of the house's Board of Managers. The patient will then have one or two interviews with Miss Gomness and may even stay to have dinner with the other residents. Miss Gomness makes the final decision as to whether or not a girl will be admitted; only she can appreciate the effect of introducing a new member into her family-like group.

Once the patient is accepted as a resident, her hospital doctor prepares a summary of her emotional history and hospital experience and tells Miss Gomness what problems may present themselves. Termi-

Healthy companionships develop from mutual help.

Dates? By all means. This girl receives a Sunday caller. House rules are few—those which would prevail in any ordinary home.

With Family Feeling

nation of residence also is reviewed by the admission-discharge committee.

The women are of different national, cultural, educational, and religious origins, with ages ranging from 16 to 40 at the present time. Each one must have some sort of constructive occupation during her stay in the house. When this article was being prepared, one resident was working full time and another part time in a speech clinic; one worked half time at a bank; one was attending a beauty culture school; and another, in anticipation of attending junior college, was working toward her high school diploma. Still another spent her days at a secretarial school. At any one time, one third of the residents may be on the day-care program of the center.

Each girl pays $15 a week for room and board. This money comes from earnings, savings, families, insurance, unemployment compensation, or disability and direct welfare funds. A capital endowment provides the rest of the operating income for the house.

Rutland Corner House, by its friendly warmth and understanding permissiveness, offers each resident companionship in a group with supportive individual attention from a staff experienced in rehabilitating the mentally ill. The small group of carefully selected residents makes for a cohesiveness that reflects a desirable quality of family life.

If an ex-mental patient is to make a success of his final readjustment to community life, it is important for him to learn or relearn social skills as soon as he leaves the hospital and before he tries to assume full responsibility for independent living. A halfway house, if it maintains a good working relationship with the referring hospital, can serve as this needed stepping stone between psychiatric illness and readjustment. •

Reading, knitting, making a hooked rug, and kibitzing others' activities occupy evenings for the stay-at-homes.

The television is always a natural focal point. Choosing and watching programs lead to pleasant girl-talk.

ANNOUNCING

The 1962 Mental Hospital Service Achievement Awards Competition

CLOSING DATE FOR APPLICATIONS MARCH 1, 1962

IN ORDER TO GIVE THE ACHIEVEMENT AWARDS COMMITTEE, a subcommittee of the Mental Hospital Service Board of Consultants, sufficient time for its deliberations, the closing date for applications for the 1962 Achievement Award Competition will be March 1, 1962.

The Awards Committee will consider any type of program for recognition, although they hope to find new and promising approaches to the whole problem of treating the mentally ill and mentally retarded in hospitals, clinics, or other facilities. Any legitimate psychiatric facility in the United States or Canada is eligible to make application: public or private mental hospitals, psychiatric units in general hospitals, schools/hospitals for the mentally retarded, mental health centers, outpatient clinics, etc. There will be no classification of awards according to the type of facility.

In 1962 the Committee hopes to award three plaques—gold, silver, and bronze—for the three programs that, in their opinion, most merit such recognition.

District Branches To Aid in Evaluations

As during the 1961 contest, local District Branches will be requested to visit each facility making an application, in order to help the Committee make evaluations and to add additional background information to assist toward the final decision.

The closing date for applications, as stated above, is March 1, 1962. Six copies of each application should be sent to the APA Central Office in Washington, D. C. Applications must not be more than six pages long, typewritten and double-spaced on one side of 8½"x11" paper, but supporting material, in the form of additional documents, charts, photographs, or newsclippings may be included. Such supporting material should be pasted or otherwise attached to an 8½"x11" sheet and clipped to the back of each copy of the written application. Six copies are needed. Please do not mount photographs, newsclippings, charts, etc., into albums.

All applications and supporting material become the property of the APA and will not be returned, except by special request, after the competition is over. Only four of the six sets of material will be returned on receipt of such requests.

Presentations To Take Place at MHI

As in previous years, the winners of the Achievement Awards will be announced and the plaques presented during the annual Mental Hospital Institute. Information about the winning programs will be published in the November 1962 issue of *Mental Hospitals,* and in the earliest possible issues of the *APA Newsletter,* and *The American Journal of Psychiatry.*

The chairman of the 1962 Committee is Stewart T. Ginsberg, M.D., of Indiana. Serving with him are Hayden H. Donahue, M.D., Arkansas, and I. Herbert MacKinnon, M.D., Georgia. Robert S. Garber, M.D., New Jersey, will continue to act as consultant to the Committee.

Address applications to: Stewart T. Ginsberg, M.D., Chairman, MHS Achievement Awards Committee, American Psychiatric Association, 1700 18th Street, N.W., Washington 9, D. C.

Have You Heard?

WORKSHOP FOR SUPERVISORY PERSONNEL AT STATE INSTITUTIONS FOR THE MENTALLY RETARDED—The Western Interstate Commission for Higher Education held its first regional workshop for top-echelon supervisory personnel employed in state institutions for the mentally retarded. The three-week staff development program provided opportunity for ten trainees to visit and work in four institutions in the state of Washington. During their training, the trainees were guests in the homes of employees who hold comparable positions.

SCHOOL FOR THE MENTALLY RETARDED—Governor Rockefeller of New York has announced the completion of preliminary plans for site development of a school for the mentally retarded at Mt. McGregor in Saratoga County. A $17-million, long-range construction program has been proposed.

New construction will include a school building, a medical-surgical building, buildings for the severely retarded, residence cottages for school children, and training and rehabilitation facilities. The new housing facilities will be built in a modified cottage arrangement with adjacent recreational areas and a centralized play field for major institutional programs. New buildings will house 1,180 patients in addition to the 345 who will be accommodated in the existing facilities after renovation. The site is adequate for expansion to provide for a total of 2,800 patients, if necessary.

COMMUNITY CARE PROGRAM FOR RETARDED INFANTS—In New York City the State Department of Mental Hygiene will offer through N.Y. Medical College and Flower and Fifth Avenue Hospital, a comprehensive program for community care of retarded infants and their families. The purpose of the program is to reduce the need for institutionalization of such children. The children will be selected from among mongoloid retardates under five years. They will receive medical, psychiatric, and social work services prior to, during, and at the conclusion of the study. Counseling for parents will also be provided.

MENTAL HEALTH STATISTICS—Chief mental health statisticians from 16 Southern states attended the annual regional conference on mental health statistics at Louisville, Ky. in October. The conference was originated in 1958 under the encouragement of the Southern Regional Education Board. The purpose of the conference is to improve the interchange of data between states and foster cooperation in the design and preparation of studies about mental health or illness. Some of the topics discussed at Louisville included the compiling of statistics for outpatient facilities and for over-all mental health programs in the states, problems in statistical reporting for mental health facilities other than hospitals, and medical records management and their usage as sources of statistics about mental health and illness.

REGISTRY OF MENTAL RETARDATION CASES—The Southern Regional Education Board, Atlanta, Ga., is maintaining the Rare Case Registry to help research persons gain access to information about rare forms of mental retardation. The registry serves as a clearinghouse for information about the location and incidence of rare cases in the South for professional persons employed in academic or clinical facilities anywhere in the 15 Southern states supporting SREB's mental health training and research program. Researchers from any discipline or profession concerned with mental retardation may have access to the registry.

EDUCATION PROGRAM FOR ADOLESCENTS—A high school education program has been organized for the increasing adolescent population at McLean Hospital, Belmont, Mass. It is hoped that this program will have state-approved courses and that the course credits will be transferable to other accredited schools when the patient returns to the community. The program is planned for eventual expansion to include adult education classes.

FURNITURE FOR CAROLINE—Patients of the U.S. Public Health Service Hospital, Ft. Worth, Texas, made a settee and a rocking chair for Caroline Kennedy. Mrs. Kennedy has expressed her appreciation in a letter to the hospital's medical officer in charge, Robert W. Rasor, M.D., for the thoughtful gesture of the patients. She thinks the furniture is "lovely and beautifully made."

HOSPITAL CLOTHING STORE — Milledgeville State Hospital, Ga., is establishing a clothing facility for its patients. A building is being converted to present the appearance of a regular clothing store, with racks, showcases, mirrors, and dressing rooms. The Georgia Association for Mental Health will cosponsor the project, and the cooperation of the people in Georgia is invited. Clothing will be donated to the store and distributed to the patients, free of charge, on the basis of need.

Patients Share "The Joy of Giving"

By EDWIN A. SHERIDAN, M.A.
Chief, Recreation Section
and ARNOLD A. SCHILLINGER, M.D.
Director,
Veterans Administration Hospital
Northport, New York

THE COOPERATION AND SUPPORT of the American Legion Auxiliary Units of Nassau and Suffolk Counties have made it possible for our hospital to provide patients with the opportunity of sharing in the joy of giving at Christmas time.

For about 15 years the Auxiliary has provided Christmas gifts for patients in VA hospitals throughout the country to send to their loved ones. Here at Northport, our present recreation staff began to help with the "Gift Shop" ten years ago, when approximately 600 patients were being served—a comparatively small number, and certainly not all of those who would have liked to take part. Our experience through the years has enabled us to introduce many refinements and shortcuts, so that today 1,700 of our 2,400 patients participate in the course of one ordinary eight-hour day.

Why are we able to serve nearly three times as many patients as 12 years ago? Because the activity has come to be accepted as useful by all divisions of the hospital; every department feels a responsibility.

When Gift Shop day rolls around, a great deal of preliminary work has already been accomplished. The staff physician and his ward team have prepared gummed labels that are addressed to the recipient, and indicate his relationship to the patient. When the patient leaves the ward, a nurse gives him his labels.

Preparation of the recreation hall starts at 8:00 o'clock on Gift Shop day. Housekeeping helps to prepare the hall (and to clean up afterward), Engineering moves tables and provides decorative Christmas trees, Laundry loans laundry carts for moving and sorting mail, the Canteen Officer takes orders for sandwiches for volunteers, Medical Illustration takes pictures to present to the Auxiliary, and Nursing cooperates to insure that every interested patient participates.

When the first group of patients arrives, some 200 American Legion Auxiliary volunteers are on the scene. A volunteer meets each patient, assists him in selecting a gift and in filling out a gift card, and escorts him to the wrapping table. Then the patient leaves the hall and his package starts through the production line, where it is wrapped, tied, labeled, weighed, stamped with precanceled stamps, and put into a mail bag.

This part of the process continues in the recreation hall until about 2:30; in the meantime, similar, smaller gift shops have been operating on seven wards for patients unable to come to the recreation hall.

Now all volunteers and participating staff members turn to completing the wrapping and mailing. The local post office supplies a mail clerk, and with his help the packages are sorted into bags according to destination. Thereby, the post office is able to place all gifts on trucks that same day.

The Reward of Giving

It was a far different story a few years ago, before we had learned the many streamlining procedures that we now use. As a single example, the lack of a sorting procedure sometimes resulted in the packages sitting untouched at the post office for several days because of the Christmas rush.

Mrs. Lena Bimlere has been chairman of the Gift Shop several times. She says, "We used to work twice as hard and twice as long and still couldn't take care of everyone who wanted to take part. Now, we know in advance how many there will be, so we are able to plan gifts, money, help, and time so well that every patient interested is able to participate."

We feel the Gift Shop serves several useful purposes. For the Auxiliary, it means an opportunity to fulfill the pledge that veterans will not be forgotten; for the hospital, it provides an opportunity to cooperate with a volunteer organization for the benefit and welfare of the patient; for both hospital and Auxiliary, it enhances good relations with the community. But most important, the Gift Shop provides patients the opportunity to remember their own loved ones at Christmas time—to share in the rewarding experience of giving. •

A Festive Program for the Holidays

At Evansville State Hospital (Indiana), we were determined last year that "left-behind" patients would have an opportunity to share in the joy of Christmas, so we initiated a program of "mixed company" buffet dinner dances. Six gala evenings provided patients with an "out-of-this-world" holiday buffet, thanks to cooperative efforts of our Dietary and Recreational Therapy Departments, who decorated the employees' dining room with a large Christmas tree, twinkling stars, and a brick fireplace hung with stockings. A buffet table, complete with turkey, baked ham, and roast beef, and individual tables decorated with Yule logs, candles, and candy canes contributed a festive note.

Each group of 140 men and women patients went through the buffet line together, then were seated together to dine to background music of strolling accordionists provided by the Evansville Musicians' Local #35—which also furnished an orchestra for dancing.

Staff members and convalescent patients served as hosts and hostesses, waiters and waitresses, cooperating in setting tables, serving potatoes, scraping dishes—whatever needed to be done.

The highly successful program is now planned as an annual event.

Ora R. Ackerman, M.Ed.
Margaret Goffinet, B.S.
Allen W. Grubb, M.S.

A Christmas Project for the "Unremembered"

Most of us think of holidays as happy days when ordinary cares are forgotten and we spend joyful hours with friends and loved ones. It is exactly at these times that the forgotten person is likely to feel his loneliness most acutely. Two years ago, we took stock of what we were doing at Central State Hospital, Indianapolis, to create a happy Christmas Day for our patients—and we decided some changes were called for.

On Christmas morning, the chaplain conducted appropriate services. But gifts had already been distributed as they had been received; pre-Christmas parties, generously provided by our state Association for Mental Health, were already memories; and many patients had gone home for the holidays, creating a "left-behind" feeling for those in the hospital. Saddest of all, 1,400 out of 2,200 patients—more than half—received no Christmas remembrance at all.

To transform Christmas from a gloomy day fraught with nostalgia for past and happier times, we first of all changed our procedure for handling incoming gifts. Packages were opened, the contents recorded, and acknowledgments sent as usual; but then, except for perishable items, we held everything for distribution on Christmas morning.

For the 1,400 patients whom nobody remembered, we collected gifts not needed for the Mental Health Association parties and gifts donated by clubs and individuals. We enlisted the cooperation of our clothing and marking rooms in providing colorful wrappings. We supplied ward lists and lists of packages received; the workers in the marking rooms then wrapped everything beautifully, ready to fill the ward barrels at the last minute. Each year, it has been touch and go—but somehow, we've found on Christmas morning that every gift was wrapped, and there was something for every patient, thanks to many thoughtful friends.

Those who donated the gifts and the time to make this possible would feel more than rewarded if they could see the difference—now that Christmas morning provides a note of cheer for patients who would otherwise spend a dreary, "unremembered" day.

C. L. Williams, M.D.,Superintendent

INBRIEF Niamid, brand of nialamide, is 1-(2-[benzylcarbamyl] ethyl)-2-isonicotinylhydrazine, a well tolerated antidepressant that may correct or relieve depression on once-a-day dosage. **Indications:** Depressive syndromes of varying degrees of severity may be responsive to Niamid including: involutional melancholia, postpartum depression, depressed phase of manic-depressive reaction, senile depression, reactive depression, schizophrenic reaction with depressive component, psychoneurotic depression. In neurotic or psychotic patients, Niamid may normalize or favorably modify aberrant or excessive reactions and symptoms of depression such as: phobias, guilt feelings, dejection, feeling of inadequacy, discouragement, worry, uneasiness, distrustfulness, hypochondriacal and nihilistic ideas, difficulty in concentration, insomnia, loss of energy or drive, indecision, hopelessness, helplessness, decreased functional activity, emotional and physical fatigue, irritableness, inability to rest or relax, sadness, anorexia and weight loss, and withdrawal from society. **In the withdrawn patient,** Niamid may elevate the mood so that there is increased activity, increased awareness and interest in surroundings, and increased participation in group activities. Appetite may be increased and there may be decreased fatigability. Lack of clinical response to other antidepressant therapy does not preclude a favorable response to Niamid. Relief of depression may also be evidenced by elimination or reduction of the need for somatic therapy, such as electroshock. **In patients suffering from depression associated with chronic illness,** Niamid may improve mental outlook, reduce the impact of pain, decrease the amounts of narcotics or analgesics needed, and improve appetite and well-being. **In patients with angina pectoris,** Niamid has been found to be a useful adjunct to management through reduction in frequency of attacks and pain. **Dosage:** Starting dosage is 75 to 100 mg. on a once-a-day or divided daily basis. This may subsequently be adjusted depending upon the tolerance and response. Responses to Niamid are not usually rapid, and revisions of dose should be withheld until at least a few days have elapsed at each level. Increments or decrements of 12½-25 mg. are generally sufficient. A daily dosage of 200 mg. is the maximum recommended for routine use. (As much as 450 mg. daily has been used in some patients.) **Side Effects:** Niamid, in clinical use, has been characterized by a significant lack of toxicity. It is generally well tolerated. Nervousness, restlessness, insomnia, hypomania, or mania, sometimes occur. Occasional headache, weakness, lethargy, vertigo, dryness of the mouth, blurred vision, increased perspiration, constipation, mild skin rash, mild leukopenia, and epigastric distress may be obviated or modified by reductions in dose. Effects due to monoamine oxidase inhibition persist for a substantial period following discontinuation of the drug. **Precautions and Contraindications:** Hepatic toxicity has not been reported in extensive clinical studies. However, if previous or concurrent liver disease is suspected, the possibility of hepatic reactions and liver function studies should be considered. The suicidal patient is always in danger, and great care must be exercised to maintain all security precautions. The apathetic patient may obtain sufficient energy to harm himself before his depression has been fully alleviated. Niamid may potentiate sedatives, narcotics, hypnotics, analgesics, muscle relaxants, sympathomimetic agents, thiazide compounds and stimulants, including alcohol. Caution should be exercised when rauwolfia compounds and Niamid are administered simultaneously. Rare instances have been reported of reactions (including atropine-like effects, and muscular rigidity) occurring when imipramine was administered during or shortly after treatment with certain other drugs that inhibit monoamine oxidase. **In Cardiology:** The central effects of Niamid may encourage hyperactivity and the patient should be closely observed for any such manifestation. Orthostatic hypotension or hypertensive episodes occur in a few individuals and cardiac patients should be carefully selected and closely supervised. **In Epilepsy:** Although in some patients therapeutic benefits have been achieved with Niamid, in others the disease has been aggravated. Care should be exercised in the concomitant use of imipramine, since such treatment with monoamine oxidase inhibitors has been reported to aggravate the grand mal seizures. **In Tuberculosis:** Existing data do not indicate whether resistance of M. tuberculosis to isoniazid may be induced with Niamid therapy; nevertheless, it should be withheld in the depressed patient with coexisting tuberculosis who may need isoniazid. As with all therapeutic agents excreted in part via the kidney, due caution in adjusting dosage in patients with impaired renal function should be observed. **Supplied:** *Niamid (Nialamide) Tablets, 25 mg.: 100's — pink, scored tablets; 100 mg.: 100's — orange, scored tablets.*

More detailed professional information available on request.

particularly useful for depressed office patients because Niamid provides:

Remission of depression—smoothly, gradually, without "jarring." Parker[1] reports that although Niamid is a slow-starting drug it produces a smoother effect than certain other antidepressants—those causing exaggerated CNS stimulant effects such as jitteriness, pressure of activity. "This is an advantage of nialamide [NIAMID] because such side effects frighten depressed patients and retard their improvement."

Notably low incidence of serious complications or side effects. After laboratory tests of patients on Niamid therapy, Ayd et al.[2] found: "Thus, in contrast to other antidepressants, nialamide [NIAMID] has not caused anemia or any disturbance in renal or hepatic function."

Convenience of once-a-day dosage.

1. Parker, S.: Dis. Nerv. System 20:2, Dec., 1959.
2. Ayd, F. J., Jr., et al.: Dis. Nerv. System 20 (Suppl.):34, Aug., 1959.

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THE HOSPITAL STORE

By R. F. DOWNEY, M.D.
Superintendent
Mayview State Hospital
Pennsylvania

EVERY HOSPITAL SHOULD PROVIDE A CANTEEN where patients and personnel can purchase candy, soft drinks, cigarettes, and tobacco. Yet so vulnerable is the administrator of a public institution that he may bitterly regret this "private enterprise" unless he has set up far more rigid safeguards than he would probably think necessary if he were a storekeeper in the community. The most obvious dangers are pilfering, embezzlement, manipulation of funds, and payroll padding. Some critics will charge that the hospital store offers unfair competition to community shops, that certain vendors get preferential treatment, that the administrator has control of the profits, and that profiteering occurs at the expense of patients and personnel.

In spite of the disadvantages, however, "going to the store" is such a normal social function that a hospital canteen can provide genuine therapeutic advantages. Patients with funds can continue to make decisions. Refreshments and lunches break the monotony of institutional food. The store makes an excellent visiting area for relatives and friends, and if it is well conducted, its profits are a valuable source of revenue to provide many social functions, materials, and recreational equipment which relieve the dreariness of hospital life.

At this 3,000-bed public mental hospital, we have a balanced program, including a main hospital store, two auxiliary canteens, and vending machines of all types. The gross business for the enterprises over the past three years has averaged $153,538 annually, with a net profit of 9.44 per cent or $14,650. A moderate reserve keeps the enterprises solvent. The hospital's only contributions are floor space and utilities. About eight full-time employees and 20 patient-employees work in the program.

We do not believe that vending machines alone will serve the hospital's purpose. The few advantages they offer are greatly overbalanced by benefits to be derived from a live trading center. The obvious advantages of mechanical merchants are availability of merchandise around the clock, minimal direct supervision, simplified bookkeeping, and minimizing of pilfering.

Their outstanding drawback is that they require purchasers to have a constant supply of small change. One nurse, in a hospital that provides only vending machines, estimated that she spent up to 20 per cent of her time obtaining and providing the 50 patients on her ward with the necessary change!

The hospital is at the mercy of the machine owners, who, even if they are honest, share but a small portion of the profits. Insuring even this small take occupies a sizable portion of one employee's duty time.

Some people advocate the use of concessionaires to run a hospital store, but we believe very strongly that this is undesirable. At best, such a store requires considerable supervision and constant consultation to guarantee service in the best interests of the patients. The revenue to the hospital is limited, and patronage may become a troublesome issue. If no alternative is possible, the administrator should insist upon a fixed monthly income, but, even with this provision, the arrangement is not ideal.

Paid Employees Versus Patient-Workers

The therapeutic values of a hospital store are sufficient to justify the use of hospital personnel and volunteers to start the project, but as soon as possible the administrator should hire a qualified manager and add other paid employees as they are needed. The conditions of employment, such as vacation, Social Security, sick time, and pay rates should parallel those prevailing in the community. Convalescent patients on leave-of-absence are often very efficient full-time employees. Patient-workers may also be used, and should receive token payment from three to seven dollars a week. Comments by other patients that the working patients get preferential treatment can be answered successfully with the explanation that employment in the store is open to any patient who is well enough and that the work performed in the store benefits everybody.

Government by a board of directors of eight to twelve members is better than autocratic control by the administrator. The superintendent, however, should serve as chairman of the board and name other members on a rotating basis. These members could be drawn from the community and from the hospital personnel and, perhaps, include a representative from the hospital's board of trustees, one person skilled in merchandising, and somebody from the volunteer service. Patients who could be useful generally stay in the hospital only briefly, but an ex-patient who has become a hospital employee can contribute greatly.

The group's name is important because respect for the group will equal the status implied by its name. This board should control the operation. It should

decide how many employees are needed, scrutinize financial reports, be certain that vendors provide good merchandise and a reasonable margin of profit for the hospital, guard the needs and rights of the patients, and promote competition which is fair to the merchants of the community. To avoid frequent and tedious meetings, a three-member operating committee can be assigned tasks and given authority to take any needed immediate action.

The controlling group should also govern the expenditure of store profits. It is wise for them to adopt a rule that precludes the use of such profits for any purpose except for material, services, or entertainment that is useful, beneficial, and available to the majority of the patients. These funds should never be used as a convenience—to avoid state purchasing procedures, for instance, or to favor a special vendor or brand. They should never be used to make a purchase that should come out of the hospital's operating budget. However, the board might decide to make one exception—to spend such profits for a single building to house the store—with the understanding that this money will be refunded later.

The operating expense of the hospital store should represent from 14 to 18 per cent of gross sales; the net profit should be between 6 and 9 per cent. Merchandising will have to be efficient to yield this profit, since tobacco products, with a very small margin of profit, make up the bulk of gross sales. Any pilfering of these items can be financially catastrophic, and for this reason, most hospitals install cigarette-vending machines as well. We recommend outright purchase of the machines at the earliest possible time; this is more profitable than a commission-type arrangement.

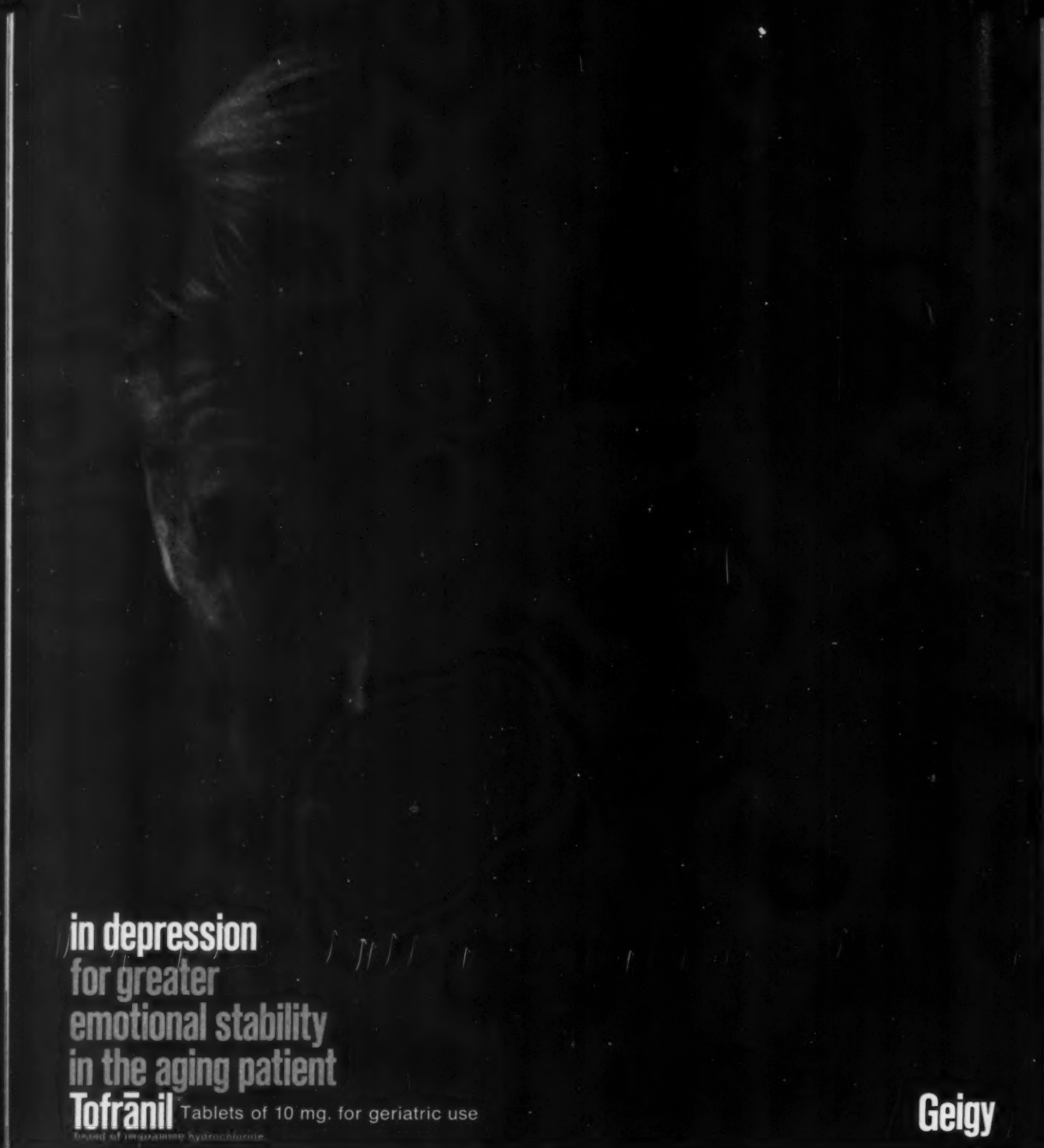
Developing a Medium of Exchange

To eliminate the problem of cash, the hospital must devise a medium of exchange for patient-trade. Metal tokens would be ideal, as they could also be used in vending machines, but their cost is prohibitive. We don't recommend store cards involving a punch system, although they are very cheap, because the liability in outstanding cards is impossible to determine without a time-consuming system of keeping duplicate cards on file to be punched simultaneously with every purchase. Coupon books best meet the problem, and any hospital with a print shop can prepare a creditable product. If there is no print shop, a substitute can be made by printing coupons on sheets and letting patients assemble them into books. If they are purchased from outside, some firms charge 5 per cent of the monetary value represented.

The store's prices should be in line with those charged by stores of like size and type in the community. Commissary privileges for personnel and the privilege of direct purchase from wholesalers will bring little other than grief to the administrator.

Among the controls we recommend are the following:

- A total inventory at least twice a year or, better still, every three months. A member of the Board of Directors should be present during this inventory. We recommend quarterly or biannual inventories rather than annual ones because the stock has a rapid turnover.
- The services of a protective agency, such as "Willmark." Such service provides supervision and encourages better service to customers and discourages dipping into the till. Its cost is scaled to the operation's size.
- The services of a certified public accountant. His fee will not be large, and he will detect leaks and defects in operation sooner than anybody else. As part of his service, he will supply a monthly statement of cash receipts and disbursements and a quarterly or biannual profit-and-loss report.
- The manager of the canteen must be bonded, and a blanket bond for all employees is prudent. The expense rarely precludes such bonding.
- A minimum of three bids should be obtained for all nonexpendable purchases for the store, such as furniture and fixtures, and for all material and items purchased out of the profits for the use of patients.
- A small percentage of the profits should be deposited in a savings account or in bonds until a reserve is created equivalent to the gross business of an average month.



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During the declining years, frustration arising from declining capacity to participate in social and family activities often leads to depression, manifested frequently in unpredictable swings of mood.[1]

The value of Tofrānil in restoring the depressed elderly patient to a more normal frame of mind has received strong support from recent studies.[1-3] Under the influence of Tofrānil, such symptoms as irascibility, hostility, apathy and compulsive weeping are often strikingly relieved with the result that life becomes easier both for the patient and those around him.

Since the dosage requirements of elderly patients are lower than those of the non-geriatric patient, Tofrānil is made available in a special low dosage 10 mg. tablet designed specifically for geriatric use.

Full product information regarding dosage, side effects, precautions and contra-indications available on request.

References: 1. Cameron, E.: Canad. Psychiat. A. J., Special Supplement 4:S160, 1959. 2. Christe, P.: Schweiz. med. Wchnschr. 90:586, 1960. 3. Schmied, J., and Ziegler, A.: Praxis 49:472, 1960.

Tofrānil®, brand of imipramine hydrochloride: Triangular tablets of 10 mg. for geriatric use; also available, round tablets of 25 mg., and ampuls for intramuscular administration only, each containing 25 mg. in 2 cc. of solution (1.25 per cent).

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Reviews & Commentary

FILM REVIEWS

MICHAEL—A MONGOLOID CHILD (14 minutes, black and white, produced by the Ministry of Health, England. Distributed by New York University Film Library, 26 Washington Place, New York 3, N. Y.)

Even before the Kennedy Administration we have seen an upsurge of interest in mental retardation, with more federal and state money being appropriated to initiate various kinds of programs for the retarded. One result of this activity has been a noticeable increase of educational material (films and pamphlets) designed to interpret the problems of mental retardation to the general public. We have reviewed here such excellent films as "Beyond the Shadows" and "Eternal Children," both of which emphasized retardation as a community problem and suggested ways of handling it (e.g., day-care centers). Although we were shown mentally retarded children in these films, it was perhaps inevitable that the chief emphasis was on the *problem,* rather than on the children themselves. Now we have a film, "Michael—A Mongoloid Child," which is all about *one* retarded child.

Teen-aged Michael lives fairly happily with his family on a potato farm in England. There are plenty of simple tasks to keep him busy, but he has time to play, too. The family, a large one, lovingly accepts Michael and his limitations, recognizing that although he does not have the worries of most teen-agers, neither does he have the pleasures. He irritates them at times, but not more so than their other children. Like many mongoloids, Michael is intensely fond of music and is allowed to select phonograph records at the family's tea-time. Because he is "on camera" practically all of the film's 14 minutes playing time, we get to know Michael fairly intimately. Furthermore, we get to know him as a *child*—admittedly a rather special child—rather than as a problem. And herein lies the film's chief virtue.

"Michael" is a curiously appealing little film that will be useful to show to the general public to enlist more interest in retardation programs; it may also be used with students of medicine, nursing, psychology, and social work. Staffs of institutions for the mentally retarded and parents of mongoloid children will find nothing especially new in the film but will find it interesting. The rural English accents are sometimes hard to understand, but Michael himself comes across beautifully.

PKU—PREVENTABLE MENTAL RETARDATION (15 minutes, color, produced and distributed by International Film Bureau, 332 South Michigan Avenue, Chicago 4, Illinois)

Phenylketonuria (PKU), though rare, is one of the few forms of pre-

"Sorry . . . no visitors. The Appropriations Committee is coming later today, and Mr. Fimble is practicing his 'dedicated' look."

"If you ask me, I think someone in Administration has this 'ward team' concept wrong."

ventable mental retardation. By means of a simple chemical test, it can now be detected about six weeks after birth, and through diet therapy, it can be treated successfully. Symptoms of PKU, a liver enzyme deficiency that eventually causes mental retardation, do not usually appear until the baby has reached the age of four to six weeks —after it has been brought home from the hospital. Since good treatment results depend upon early diagnosis, medical authorities are attempting to screen all children coming to clinics and hospitals.

This brief but highly informative film is made up chiefly of clinical tests in which the audience sees the success of early treatment and the tragic results when PKU is too long undetected. This absorbing material is by Richard Koch, M.D., University of Southern California School of Medicine and the Los Angeles Children's Hospital, who is an authority on PKU diagnosis and treatment. The explanations of the disease, its detection and therapy, are clear and would be understandable to lay audiences. The film could be used, therefore, to educate parents to have their children tested. It could also be used with physicians, public health nurses, and medical social workers. The production is a thoroughly professional one, and the color photography has been used advantageously. This interesting illustrated lecture will be useful in mental retardation programs.

JACK NEHER
Mental Health Materials Center

BOOK REVIEWS

THE MENTALLY DISABLED AND THE LAW—edited by Frank T. Lindman and Donald M. McIntyre, Jr., Chicago, University of Chicago Press, 1961, 445 pages, $7.50.

This large volume constitutes the report of the American Bar Foundation on the Rights of the Mentally Ill, which, since 1956, has been engaged in a monumental study of state laws relative to the mentally disabled. The text and 42 tables present the various legal provisions of the states and of the Health, Education, and Welfare Draft Act governing the hospitalization of the mentally ill. There are 11 chapters, plus four appendixes and three indexes. Recommendations follow each chapter.

This report is not final. A Psychiatric Advisory Committee has been activated, and field studies, financed by a grant from the National Institute for Mental Health, are being conducted in several states. Dean Pound long ago pointed out that one must study the law not only in books but also in action; this is what the Committee is doing.

Everyone connected with mental hospitals or with courts making

judgments regarding the mentally disabled should be familiar with the contents of this book. It is truly, as the publishers claim, the first comprehensive American treatise on mental disability laws.

WINFRED OVERHOLSER, M.D.
Washington, D. C.

In 1945 the American Bar Association recommended an analysis of the law as it relates to emotionally ill people and established a foundation which, in 1954, embarked on a study of the subject. This book is the report of that study.

It covers voluntary and involuntary hospitalization; guardianship; criminal responsibility; release from hospitals; incompetency; and the medicolegal aspects of marriage, divorce, sexual psychopathy, and eugenic sterilization. Each chapter is followed by tables of each state's laws, showing where "menace" is the sole criterion of commitment, which states accept "irresistible impulse" as a defense for crime, where a physician's license is not revoked because of psychosis, and which jurisdictions automatically restore a patient's civil rights after his discharge from a mental hospital. The tables are not easy reading but are a wonderful reference source.

Each chapter closes with recommendations, some of which are pious generalities. Others are crisp, concrete, and clean-cut, although many readers may disagree with them. In the first "against sin" category there are such suggestions as: a patient's property rights should not be neglected; there should be less confusion about the status of voluntary patients; certain types of patients now in mental hospitals could be better cared for in other ways; and eugenic sterilization statutes should afford every reasonable protection to the individual concerned.

Authors of the study recommend that every allegedly mentally ill person be represented by counsel (at state or county expense if he is indigent) before commitment. They urge that all prospective patients be given "notice," neutralizing this recommendation by adding that notice may be dispensed with "if the court is convinced that substantial harm would result." They also recommend periodic re-examination of all patients in mental hospitals to determine their fitness for discharge. It's a fine idea—if a psychiatric staff could be found to do a million and a half examinations a year. If all of the country's psychiatrists gave up their private practices and collaborated with all of the mental hospital doctors (whose other activities would have to cease), the examinations just might be possible.

However, each chapter is solid and informative and well documented, too. For instance, in the chapter on criminal responsibility, 392 footnotes heckle the reader; this may exemplify good legal writing, but is a bit exhausting for physician-readers.

One of the authors' more intriguing suggestions is to develop

a statewide registry of incompetents so that innocent tradespeople might be protected from doing business with them. This is an interesting illustration of the liberal lawyer's dilemma. He wants to protect everybody's rights!

One of the tabulations shows the effect of mental disorder on the right to practice a profession or skill. Here we learn that hospitalization for an emotional disorder can suspend the license of an undertaker or of a pest-control operator in California, a psychologist in New Hampshire, a cosmetologist in Arkansas, an airplane pilot in Georgia, a taxi driver in Delaware, an obstetrician in Nevada, a physical therapist in Maine, and an ophthalmic technician (but not a doctor) in New Jersey.

A good chapter on the medicolegal aspects of the sex psychopath brings some order to this chaotic subject. While reading this and many other parts of the report, psychiatrists will realize that it is helpful to have some of their thinking filtered through the more semantically precise minds of lawyers.

The tightly reasoned and sophisticated monograph on criminal responsibility is worth the price of the book. The authors do not wholly approve of any existing formula for appraising criminal responsibility. They want to broaden the class of those who can be held criminally irresponsible. They also want to canonize the views of impartial experts, but they don't say how these experts could escape from their own personal biases in evaluating this emotionally loaded question. In good lawyer-like fashion, they would "prevent impartial experts from testifying concerning self-incriminatory statements the accused might have made during the examination." Just how the psychiatrist could disentangle the self-incriminatory statements from other statements counsel sayeth not. Testimony given by the impartial expert under these conditions would provide a field day for the defense counsel. The authors favor a place for the doctrine of partial responsibility.

The book includes four valuable appendixes, and its usefulness is enhanced by three handy indexes. All in all, it is the definitive volume of its kind: a fact-filled, thought-provoking almanac for the psychiatrist who—whether he likes it or not—is drawn into forensic problems. And that could mean any of us.

HENRY A. DAVIDSON, M.D.
Cedar Grove, N. J.

THE MENTALLY RETARDED AND THEIR VOCATIONAL REHABILITATION—by William A. Fraenkel, Ph.D., New York, National Association for Retarded Children, 1961, 80 pages, 50¢.

This pamphlet, clearly printed and arranged for easy reading, is directed to the vocational counselor and others interested in the rehabilitation field. It provides background medical information about

retardation, the process of preparing a client for referral for rehabilitation, the counseling process, community facilities, and the range of a retarded person's rehabilitation needs. Brief case histories, names of community rehabilitation resources, and bibliographies are included in this excellent reference and source book for all who work to rehabilitate retarded adolescents and adults for vocations.

LUCY OZARIN, *M.D.*
Kansas City, Mo.

VOLUNTEER SERVICES IN MENTAL HOSPITALS—New York, National Association for Mental Health, Inc., 1961, 250 pages, $1.00.

This paperback book is a report of the first nationwide Institute for Directors of Volunteer Services in Mental Hospitals, held February 8-19, 1960, in Topeka, Kansas. The Institute was sponsored by the NAMH, Menninger Foundation, and Topeka State Hospital with the support of the National Institute for Mental Health and the Nathan Hofheimer Foundation.

The book is based on lectures delivered by a faculty chosen from several mental health professions, hospital administrators, state mental health officials, representatives of government agencies and voluntary organizations, personnel and public relations experts, and experienced local and state directors of volunteer programs. Group discussions of participants in the Institute and records of achievement of volunteer-service departments in a number of state hospitals and schools for the mentally retarded supplement the lecture material.

Three chapters—"The Patient," "The Hospital," and "The Community"—deal with areas of knowledge that are essential to understanding the groups and individuals with whom a director of volunteers has continuing contact. Other chapters discuss the philosophy of volunteer service, public and private agencies, the necessary personal and professional qualifications to be a director of volunteers, the organization and operation of programs, the role of a state coordinator of volunteer services, and additional subjects relevant to the work of the citizen-volunteer in psychiatric hospitals. Suggestions and guidance are offered to all who are interested in organizing, directing, and participating in volunteer programs in public hospitals for the mentally ill and schools for the mentally retarded. The differing problems of rural and urban hospitals are discussed realistically.

On the whole, the volume is packed with many practical suggestions, but suffers somewhat—as do most secondhand-edited reports—from loss of the personal flavor of the contributors. But it makes up for this by being, basically, a reference work that will be helpful to those who are concerned with volunteer services. It might also be useful as a tool for evaluating existing programs.

ALFRED K. BAUR, M.D.
Fulton, Missouri

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News and Notes

Rockefeller Public Service Award

Robert Hanna Felix, M.D., has been awarded the 1961 Rockefeller Public Service Award in the area of Science, Technology, and Engineering. The award, one of the highest forms of recognition given career federal employees, is based on achievement and long distinguished career service. Each winner receives a cash gift of $5,000, as well as the privilege of devoting some time to lecturing, writing, or conducting a counseling program at a university of his choice. Awards are made possible by a fund established by John D. Rockefeller 3rd and are administered as a national trust by the Woodrow Wilson School of Public and International Affairs at Princeton University.

Dr. Felix said he hopes to launch a study of methods of wining public acceptance of public health programs, an idea he has had for 20 of his 30 years in government service. In the mental health field such a study would cover the attitudes of families, the community, and employers toward recovered mental health patients.

Dr. Braceland Honored

Francis J. Braceland, M.D., psychiatrist-in-chief of The Institute of Living, and APA Past-President, has received the Connecticut State Bar Association award for distinguished public service. He was cited for his contributions as physician, educator, writer, lecturer, and leader in community affairs and public welfare.

Shneidman on Suicide

"The second suicide attempt rather than the first is often the one that works," said Edwin S. Shneidman, M.D., co-project director of the Suicide Prevention Center, Los Angeles, Cal. Dr. Shneidman addressed an audience of psychiatrists and other mental health professionals at a lecture on suicide, sponsored jointly by Forest Hospital, a psychiatric facility in Des Plaines, Ill., and the Chicago Board of Health. Another speaker at the meeting was Harold Visotsky, M.D., director of the Chicago Board of Health's mental health section. D. Louis Steinberg, M.D., an instructor in psychiatry at Northwestern University Medical School, was chairman of the meeting.

The lecture, presented as a professional service by the hospital, was the first in a series of nine such talks to be given monthly through June 1962. Dr. Shneidman stated that the findings of the government-sponsored Suicide Prevention Center indicate that "most suicides occur within the three months following the first unsuccessful attempt." He warned that relatives and physicians should be especially vigilant for signs of impending suicide at "the very moment when the individual is showing improvement." The time of crisis occurs when the patient has recovered sufficiently from his first unsuccessful try to "mobilize new energy to put his morbid thoughts into effect."

It is not true that people who threaten to commit suicide seldom do. "Suicide threats must be taken seriously," Dr. Shneidman added. "They are often warnings of the impending act, offered by persons who wish to be saved by outside help from committing the final deed." Eight out of 10 suicides have given definite hints of their intentions.

". . . suicide today is . . . among the first 10 causes of death in the adult population and, at the same time, is relatively neglected scientifically," Dr. Shneidman stated, decrying the lack of treatment and surveillance accorded the serious suicide risk. "Each new suicide attempt," he warned, "tends to be more deadly than the last."

Advance signs of possible suicide may be seen in behavior changes—withdrawal from loved ones, loss of appetite and sex drive, and boredom with work and hobbies. More men than women succeed in suicide, mainly because they choose such devices as guns and ropes, while women often resort to less deadly means, such as pills or a cut wrist.

Dr. Shneidman and his colleagues have reached the conclusion that perhaps 70 per cent of the people who commit suicide are not certain that they wish to die. Most of them have left some kind of "cry for help," indicating a desire to be rescued from their impulse. A tendency toward suicide does not run in families, nor is suicide confined to an economic class. Most suicides, but not all, show symptoms of depression. Many also show agitation and anxiety, "or just subtle changes of appetite or energy."

The Suicide Prevention Center is located in the Los Angeles County Hospital and is maintained by a grant from the U.S. Public Health Service, administered by the University of Southern California.

VA Personnel Title Changes

Top personnel of VA medical installations across the nation have been given new titles. Managers of VA hospitals, domiciliary centers, and outpatient clinics have the new title of director; assistant managers are now assistant direc-

tors. Directors of professional services are designated now as chiefs of staff, and assistant directors of professional services for research and education are associate chiefs of staff. The redesignations were made to provide more suitable titles. No changes in duties, pay, or military status are involved, however.

Community Project Grants

Applications for grants authorized by the new Community Health Services and Facilities Act are now being accepted by the Public Health Service. Grants will be made for developing, demonstrating, or studying new methods of providing health services, particularly for the chronically ill and aged.

The types of projects eligible for aid include home-nursing services for the chronically ill and the aged, improvements in the care of patients in nursing homes, and programs for making therapeutic and other services available to patients in their own homes. To qualify for a grant the project must be useful to the community that conducts it, and must show promise of providing new knowledge that will be helpful to other communities in developing similar services.

Application blanks are available from Public Health Service staff in all regional offices of the U. S. Department of Health, Education, and Welfare and from the Grants Management Branch of the Bureau of State Services, Public Health Service, Washington 25, D. C. Regional office staffs are available to help applicants develop project proposals.

Mental Hospitals Reprint Service

Readers frequently request reprints of articles in *Mental Hospitals* for distribution to others for various educational and informational purposes. The price list and order form below have been devised to simplify the procedure for obtaining reprints. Since it is not economical to reprint less than 100 copies, the minimum price is based on that number. Reprints are exactly the same size as the originals in the magazine and take the same number of pages. Prices quoted include handling and shipping costs. *Please enclose a check or money order for the exact amount with your order.* Delivery will take approximately three weeks.

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PEOPLE and PLACES

KENTUCKY: **Cynthia Rector, R.N.,** is the new supervisor of psychiatric nursing at Norton Memorial Infirmary, Louisville. Formerly, she was instructor in psychiatric nursing at the infirmary's school of nursing.

Joseph D. McGee has been appointed administrator of Central State Hospital, Lakeland. Mr. McGee was previously assistant administrator at Saints Mary & Elizabeth Hospital in Louisville. HERE & THERE: **Sister M. Louise, D.C.,** has been named administrator of the Seton Psychiatric Institute, Baltimore, Md. **Sister Gertrude** is the Institute's new assistant administrator, and **Sister Mary Agnes,** the newly appointed director of nursing.

John H. Reitmann, M. D., has resigned as superintendent of Hastings State Hospital, Minnesota. Dr. Reitmann will enter private practice in Dallas, Texas.

Marvin E. Perkins, M. D., became New York City's first Commissioner of Mental Health Services on October 31. Dr. Perkins was director of Community Mental Health Services for the city as well as the chief executive officer of the New York City Community Mental Health Board.

Virginia E. Pancost, R.N., has retired as chief nurse of Elgin State Hospital, Ill. Miss Pancost had

been on the hospital's staff since 1950.

Leonard W. Lavis is acting superintendent of Glenwood State School, Iowa. Mr. Lavis was previously a community consultant for the eastern section of Iowa. He succeeds **Peter A. Peffer, M. D.,** who resigned to become superintendent of Paul A. Dever School at Taunton, Mass.

Humphry Osmond, M. D., has resigned as superintendent of the Saskatchewan Hospital, Weyburn, Canada. **I.L.W. Clancey, M.D.,** formerly the hospital's clinical director, has been appointed as successor to Dr. Osmond, who will return to England.

A children's treatment and education unit has been organized at the **Winnebago State Hospital** near Oshkosh, Wis. Charles Belcher, M.D., superintendent of the hospital, said that the children's unit will have about 100 patients, from five to 18 years of age. In addition to therapy and psychological evaluation, the unit's basic program will provide formal classroom instruction.

DEATH: **Henry William Lloyd, M.D.,** psychiatrist and owner of the West Hill Sanatorium, New York City, died October 7. Dr. Lloyd owned and operated the sanatorium for 30 years.

AWARD: **Sister Mary Bernard, C.I.J.,** administrator of Mercy Hospital, Rockville Centre, Nassau County, N.Y., was the recipient of the Nassau Neuropsychiatric Society's Annual Award for 1961. The Society presents the award in recognition of the person whom it considers to have contributed the most in the advancement of Mental Health in Nassau County during the year. The Society is an APA District Branch.

CORRECTION

In the October 1961 issue of *Mental Hospitals*, the title of the Current Study on page 61 should have read: "Exploring Social Service Discharge Plans for Mental Patients. Part I: Ward Resocialization Program."

QUARTERLY CALENDAR

APA ANNUAL MEETINGS

1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 6-10, Chase-Park Plaza Hotel, St. Louis, Mo. (119th)

APA MENTAL HOSPITAL INSTITUTES

1962 Sept. 24-27, Americana Hotel, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Sheraton-Gibson Hotel, Cincinnati, Ohio (15th)
1964 Sept. 28-Oct. 1, Hotel to be announced, Boston, Mass. (16th)

OTHER APA MEETINGS

Executive Committee Meeting, January 15, 1962, APA Central Office, Washington, D.C.

Regional Research Meeting, January 19-20, 1962, Los Angeles, Cal. (Inq. Dr. Edward Stainbrook, 1934 Hospital Pl., Los Angeles 33, Cal.)

CANADIAN MENTAL HEALTH SERVICES INSTITUTE

1962 January 15-18, Chateau Laurier Hotel, Ottawa, Canada (2nd) (Inq. Dr. V. E. Chase, Canadian Psychiatric Assn., Suite 103, 225 Lisgar St., Ottawa 4, Ontario.)

OTHER PROFESSIONAL MEETINGS

Association for Research in Nervous and Mental Disease, Annual Meeting, December 8-9 (Inq. Dr. Rollo J. Masselink, Sec., 700 W. 168th St., New York 32, N.Y.)

American Psychoanalytic Association, Fall Meeting, December 8-10, Biltmore Hotel, New York, N. Y.

Academy of Psychoanalysis, Midwinter Meeting, December 9-10, New York, N. Y. (Inq. Dr. Joseph H. Merin, 125 E. 65th St., New York 21, N. Y.)

American Board of Psychiatry and Neurology, Examination for certification in P&N, December 11-12, New York, N. Y. (Inq. Dr. D. A. Boyd, Jr., 102 2nd Ave., S.W., Rochester, Minn.)

American Association for the Advancement of Science, Annual Meeting, December 26-31, Denver-Hilton Hotel, Denver, Colo.

Association for Psychiatric Treatment of Offenders, Annual Meeting, January 17, 1962, Academy of Sciences, 2 E. 63rd St., New York, N. Y.

Royal College of Physicians and Surgeons of Canada, Annual Meeting, January 18-20, 1962, Chateau Laurier Hotel, Ottawa, Ont., Canada

National Association of Private Psychiatric Hospitals, Annual Meeting, January 22-24, 1962, Colony Beach Resort, Sarasota, Fla.

American Group Psychotherapy Association, Annual Meeting, January 24-27, 1962, New York, N. Y.

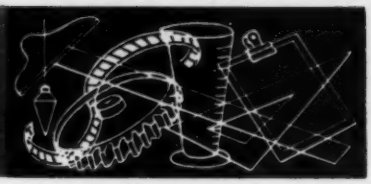
National Society for Medical Research, Annual Meeting, February 6, 1962 (Inq. Ralph A. Rohweder, Exec. Sec., 920 S. Mich. Bldg., Chicago 5, Ill.)

American Academy of Occupational Medicine, Annual Meeting, February 7-9, 1962, Hilton Hotel, Pittsburgh, Pa.

American Academy of Forensic Sciences, Annual Meeting, February 22-24, 1962, Drake Hotel, Chicago, Ill.

American Psychopathological Association, Annual Meeting, February 23-24, 1962, Park-Sheraton Hotel, New York, N. Y.

Admin. Abstracts



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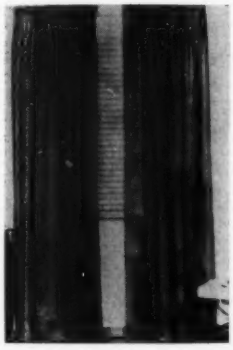

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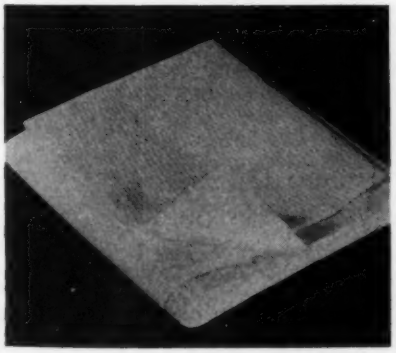

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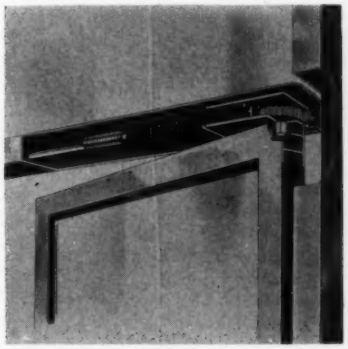

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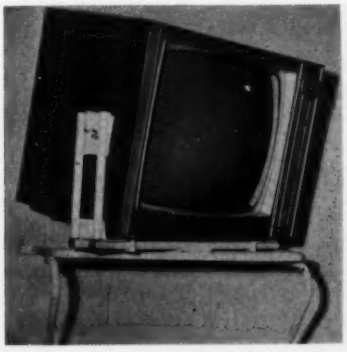

ing Corporation, 234 E. College Ave., State College, Pa., permits rotation and tilting of the TV set. The bracket can be fastened by lag or toggle bolts to a solid substantial wall. Write manufacturer for further information.

AIDS & FILMS

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Illustrated Medical Lectures

The School of Medicine of the Loma Linda University, 1720 Brooklyn Ave., Los Angeles 33, Cal., offers postgraduate extension courses in medicine through use of audiovisual lectures. Each course consists of a 30-minute audio tape and a full-color 35 mm filmstrip, which can be projected on a screen or viewed through a hand or desk viewer. Psychiatry is included in the current library of 30 audio-visual lectures, augmented monthly by the addition of three new filmstrips.

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1961 INDEX Mental Hospitals *VOLUME XII*

Authors

Subjects

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*Ayd, Frank J., Jr.: Drug-induced Extrapyramidal Reactions: Their Clinical Manifestations and Treatment with Akineton. Psychosomatics 1:143 (May-June) 1960.

KNOLL PHARMACEUTICAL COMPANY, ORANGE, NEW JERSEY

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STATEMENT REQUIRED BY THE ACT OF AUGUST 24, 1912. AS AMENDED BY THE ACTS OF MARCH 3, 1933, JULY 2, 1946 AND JUNE 11, 1960 (74 STAT. 208) SHOWING THE OWNERSHIP, MANAGEMENT, AND CIRCULATION OF MENTAL HOSPITALS, published monthly at Baltimore, Maryland, (except July and August) for December 1, 1961.

1. The names and addresses of the publisher, editor, and managing editor and business manager are:

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5. The average number of copies of each issue of this publication sold or distributed, through the mails or otherwise, to paid subscribers during the 12 months preceding the date shown above was: (This information is required by the act of June 11, 1960 to be included in all statements regardless of frequency of issues.) 12,500. Mathew Ross, M.D., Editor. Sworn to and subscribed before me this 29th day of November, 1961.
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references
(1) Winkelstein, A.: Am. J. Gastroenterol. 27:45-52 (Jan.) 1957.
(2) Pareira, M. D., *et al.*: J.A.M.A. *156*:810-816 (Oct. 30) 1954.

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